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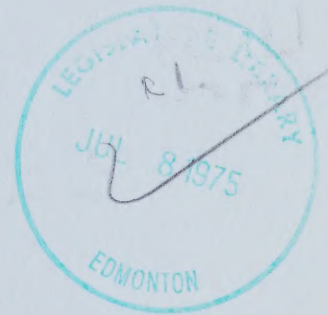
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Evaluation Report on the Drug Information
Center - Calgary.



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EVALUATION REPORT ON THE DRUG INFORMATION CENTER CALGARY



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JULY 9, 1975

An evaluation report on the Drug Information Centre, Calgary, recommending that Preventive Social Service legislation channelled through the city be used to finance the centre, was released today by Social Services and Community Health Minister Helen Hunley.

The role of the centre since it first began operation in 1969 to meet "crisis" needs has changed extensively to meet the total social needs of clients say the authors, L.F. Heinemann and F. Storey.

The centre's funding has come from a variety of sources, both voluntary and public, with direct funding assistance coming from the Alberta Alcoholism and Drug Abuse Commission.

The researchers however, said that if the center is to become permanently established it likely would have to rely totally on government funding and suggested the existing method of funding limited the centre to programs for which it knew it could get funding rather than embarking on needed programs for which it could get no funding support.

The evaluators found the prime value of the centre was that the treatment and referral processes were entirely confidential and therefore appealed to a particular area and socio-economic group. They also found there was little overlap between services provided at the centre and those provided by other agencies.

It was suggested the volunteer training program which has showed a good deal of success with limited resources, be expanded and strengthened.

Mr. Heinemann, a private social service consultant from Regina, was program officer of demonstration projects, national health and welfare from 1968 to 1973. From 1973 to 1974, he served as executive director of the Saskatchewan government's Human Resource Development Agency.

EVALUATION REPORT ON THE
DRUG INFORMATION CENTER
CALGARY

PREPARED FOR
THE HONORABLE NEIL CRAWFORD
MINISTER OF HEALTH AND SOCIAL DEVELOPMENT

Prepared by - L. F. Heinemann
B.Ed., A.M., R.S.W.
- F. Storey
B.A., M.A.

March 15, 1975

The commissioning of this study does not imply concurrence with the views expressed in the report. L.F. Heinemann and F. Storey bear sole responsibility for the entire report.

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PREFACE

The Calgary Drug Information Center was one of many projects and new services developed across Canada in the late 1960's and early 1970's in response to the perceived Drug Crisis problems. As one experiment among many, it has been more successful in establishing itself and in gaining community support than have many similar undertakings. For this reason, the evaluation takes on added significance and will potentially be of value to others in other parts of Canada who are interested in this problem area and who may be able to use some of the ideas and practices developed by the Center.

Although there have been a number of other efforts to evaluate the activities of the Center, all have been of limited scope, have tended to concentrate on a limited methodology, namely observation, or have been carried out by persons and agencies having a vested interest in the outcome of the evaluation. These efforts, therefore, have raised questions about the validity of the results. The authors of this report have used a summative approach to evaluation, i.e. have relied on a variety of methods to gather and assess the information and have gathered that information from a variety of sources. This has enabled comparisons to be made between sources of information and methodologies in an effort to check the reliability of the information and to validate findings. We trust the presentation of our findings will be comprehensible to all interested parties and accepted as an effort to bring objectivity into the evaluation process.

The authors recognize that not everyone is going to agree with or be happy with all of the conclusions we have drawn, or the recommendations we have put forward. We, however, present this report with the hope that parties will be able to accept it as the basis for future discussions, negotiations, decisions and commitments about the Center and its future role and concerning how resources will or will not be channelled to make that future role possible.

THANKS

The Calgary Drug Information Center was one of many projects and new services developed across Canada in the late 1980's and early 1990's in response to the perceived drug crisis problem. As one experiment among many, it has been successful in establishing itself in gaining community support than have any similar undertakings. For this reason, the evaluation team of added significance and will potentially be of value to other parts of Canada who are interested in this model and who may be able to use some of the ideas and practices developed by the Center.

Although there have been a number of other efforts to promote the activities of the Center, all have been limited either by limited resources, or have been carried out in a piecemeal fashion, or have been carried out in a way that has not resulted in the same level of the evaluation. These efforts, therefore, have raised questions about the validity of the results. The authors of this report have used a narrative approach to evaluation, i.e. have relied on a variety of methods to gather and analyze the information and have gathered that information from a variety of sources. This has enabled comparison to be made between sources of information and methodology in an effort to check the reliability of the information and its validity. We trust the presentation of our findings will be understandable to all interested parties and will be an effort to bring objectivity into the evaluation process. The authors recognize that not everyone is going to agree with or be happy with all of the conclusions we have drawn, or the recommendations we have put forward. However, present this report with the hope that people will be able to accept it as the basis for future discussion, decisions and comments about the Center's role and concerning how resources will be allocated to make that future role possible.

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ACKNOWLEDGEMENTS

The Authors wish to acknowledge with thanks the assistance received from many persons and organizations in Calgary whose assistance made it possible to obtain the information for this report. This information was obtained both through personal contacts and from recorded data, reports and proceedings.

Specifically thanks are due to the Drug Advisory Council; the Director of the Center, Penny Cairns; members of her staff and volunteers, past and present, of the agency, without whose co-operation and participation it would not have been possible to carry out the evaluation. Thanks must also go to staff and administrators of numerous agencies which are listed in Appendix F to this report. Thanks must also go to the Mayor, the Chief of Police, and several Calgary M.L.A.s who took time out of their busy schedules to be interviewed.

Special mention must also be made of the assistance rendered by John Mould and Marie Parent, who conducted the telephone survey and the interviews with a small sample of agency clients, as well as those members of the general public and of the Center's clientele who allowed themselves to be interviewed.

Thanks also must go to Senior staff of the City Social Service Department, A.A.D.A.C. in Edmonton, and the Department of Health and Social Development, Edmonton, who assisted in making available records, provincial Hansard proceedings and who assisted in making arrangements, etc.

Because of the excellent co-operation received from all segments of the Community, the task of the evaluators was made easier than had been anticipated.

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THE CALGARY DRUG INFORMATION CENTER
AN EVALUATION REPORT

SECTION I BACKGROUND

I INTRODUCTION

This report is a review and evaluation of a Drug Information and Crisis Intervention Program implemented by the Drug Advisory Council of Calgary over the period from April 1970 to February 1975. The evaluation was undertaken at the request of The Honorable Neil Crawford, Minister of Health and Social Development.

The report is presented in a form which should make it comprehensible to both those who have knowledge of the Drug Information Center and its activities and those who had no prior knowledge of the Center. The report briefly examines the historical background of the program including events leading to its inception and why and how the program was implemented. It also examines the results obtained as viewed by various participants and where possible, validates these results with recorded information and factual data. Conclusions on results of the program are drawn, based on the information available and the report sets forth some recommendations as suggested guidelines for future programming.

For purposes of simplicity, the following abbreviated forms will be used when referring to key organizations concerned in or with the evaluation:

- a) Drug Information Center - The Center
- b) The Alberta Alcoholism and Drug Addiction Commission - A.A.D.A.C.
- c) The Department of Health and Social Development - the Department.

II EVENTS LEADING TO THE IMPLEMENTATION OF THE CENTER PROGRAMS

In the late 1960's, the youth phenomenon which was characterized by substantial numbers of unemployed

transients and the rejection of more traditional social values as dramatized by the increasing use of non-alcohol drugs, had reached its peak. The resultant social problems were creating considerable alarm across Canada. The general public, the police, social agencies, etc. were all exerting increasing pressure on governments to take remedial action. This led to the LeDain Commission on the non-medical use of drugs and some hastily planned summer employment and hosteling programs by the Federal Government. The Federal Government also began some experimental projects designed to seek new ways of relating to the needs of transient and alienated youth. These efforts combined with recommendations contained in the preliminary report of the LeDain Commission led to the establishment of the Directorate on The Non Medical use of Drugs, within the Department of National Health and Welfare. Its purpose was to carry on research and experiment with activities of a preventive educational, treatment and rehabilitative nature.

Most provinces and municipalities found the issue too politically contentious to get involved without considerable outside pressure being exerted. Alberta and in particular Calgary proved to be exceptions to this general reaction. As a result of concern by many citizens and responsible community officials, the Drug Advisory Council was established. The Drug Advisory Council was composed of members of The Drug Task Force, a local group established to study the problem and members of the Alcohol Education Association, an existing community group.

It was proposed that the Drug Advisory Council would establish a Drug Information Center. The Center would be the program arm of the council and would implement the following needed programs:

1. Information Service - professional and lay
2. Crisis and Information Center operated 24 hours per day with volunteers

3. Referral service to existing services
4. A core of suitably trained and competent volunteers to man the Information and Crisis Service on a 24 hour a day basis.
5. Seconded staff to participate in training, and to help develop the education, information and crisis counselling services.
6. Provision for back up professional advice and consultation.
7. Arrangements to have access to hospital emergency departments as necessary.

The proposal and the program which the Drug Advisory Council then proceeded to implement was based on the findings of the task force. These findings indicated that:

1. Little accurate or reliable information on drugs and their effects was available.
2. Many young people on bad trips did not make use of the existing hospital emergency services.
3. There was a general lack of services and resources to deal with drug and drug related problems.

One of the initial problems faced by the Drug Advisory Council was to secure the necessary funding, resources and facilities for the program. Negotiations with the provincial Health Department resulted in an initial grant of \$10,000 in 1970. A local company donated a location, and staff were seconded to work with the center by A.A.D.A.C. and the Alcohol Education Association.

To minimize legal problems related to funding, monies were to be made payable to the Alcohol Education Association. This organization in turn gave the money to the Drug Advisory Council for its use. The program of the Center and how it evolved and changed will be described in more detail in Section III of the report.

III EVENTS LEADING TO THE REQUEST FOR THE EVALUATION

a) PREVIOUS EVALUATION EFFORTS

After having provided the funds for two years for the major portion of the Center's expenditures, A.A.D.A.C. in March of 1973 began to question whether it should have a continuing role in the funding of Center programs. An initial grant covering a three month period was approved and the funding for the remainder of the fiscal year was to be subject to a further review and evaluation of the Center's activities. Several efforts at evaluation followed.

1. The Gladders Study

This study was undertaken by Dave Gladders, a summer employee of A.A.D.A.C. Although the Center was informed that an evaluation would take place, there appears to have been no consultation as to how this would be done. Correspondence indicates that the Center objected to some of Mr. Gladder's methods and questioned A.A.D.A.C.'s right to undertake the evaluation. A.A.D.A.C. was equally insistent that it reserved the right to undertake a full review of any program for which it was providing major funding.

An acceptable approach was finally agreed to by the Center and Mr. Gladders proceeded with his study. The study was based on the use of the observation method. Mr. Gladders spent two weeks observing and noting activities carried out by the Center. Since he could not spend a full twenty four hours at the Center, time sampling was used to ensure that he would have some records which would reflect the Center's total activities during the observation period. These observations were compared to the record of activities maintained by the Center's staff and volunteers during the same period. Mr. Gladders report was augmented with descriptive information about the Center's program and of the implementation procedures. The statistics produced by

Mr. Gladders were similar in quantity to those kept by the Center. However, according to Dr. Nutter, A.A.D.A.C.'s Research Director, the Center interpretes these statistics differently than A.A.D.A.C. The Center claimed that most of its contacts were service contacts, whereas A.A.D.A.C. interpreted many as housekeeping and administrative contacts. Based on its observation, A.A.D.A.C. concluded that the Center was not performing functions which were significantly related to A.A.D.A.C.'s priorities, ie. treatment and rehabilitation.

The Center protested that the study was inadequate. As a result, it was agreed to release funds for the remainder of the 1973-74 fiscal year. It was also agreed to carry out a further evaluation which was to be funded by the Non Medical Use of Drugs Directorate.

2. The McAmmond Study

During the months of July and August, a total of five agencies serving individuals experiencing drug or alcohol problems were surveyed under the direction of Diane McAmmond. The Center was one of these. The study was designed by Ms. McAmmond and Dr. Nutter of A.A.D.A.C. The methodology was again based on direct personal observations. This was augmented by the interviewing of some staff and volunteers and the gathering of background historical and program data on the Center. Also, efforts were made to record observations according to categories being used by the Center. A total of seventy hours was spent in observing the Center's activities.

The report summarized the findings based on observations in both narrative and statistical form. These findings were presented along with a general description of the programs and activities in which Center staff and volunteers were involved. The report concluded that the Center offered a competent and efficient service to the public regarding the distribution of drug information and the alleviation of short-term drug crisis problems. The report further stated that the evaluator believed the Center was neglecting its duty by not providing a similar crisis and referral service to alcoholics.

The report concluded by stating, "I do not feel that it would be unfair to state that, though short-term alleviation of drug problems is important, D.I.C. is performing at a much less effective level than it might by failing to orient the drug abusing or alcohol abusing individual towards a long-term source of rehabilitation".

b) THE DECISION TO DISCONTINUE THE FUNDING

Again the statistics produced by the study agreed with those of the Center but there was disagreement over the nature of those activities, i.e. were they housekeeping and administrative or service oriented. A.A.D.A.C. concluded from these two studies that the activities of the Center, though worthwhile, were of a general nature, not specifically oriented to the drug problem. It further concluded that the activities of the Center were not sufficiently related to A.A.D.A.C. priorities, i.e. treatment and rehabilitation, to justify continued funding.

No funds were put into the A.A.D.A.C. budget to fund the Center in the fiscal year 1974-75. At the same time, agencies were informed that A.A.D.A.C. was changing all funding from grants in aid to a purchase of services, on a fee for service basis. The rationale used was that this was the only way that the province could get cost sharing from the Federal Government under the Canadian Assistance Plan. All agencies receiving funds were so informed. Agencies were asked to make submissions on this basis, for assessment by A.A.D.A.C. The Center rejected this as an appropriate way of funding its services. There were some discussions with several A.A.D.A.C. members by the Center's Director, Penny Cairns and the Center's board, the Drug Advisory Council. The Center interpreted these discussions to indicate that A.A.D.A.C. wanted either to take over the Center's operation or force the Center into the field of treatment and rehabilitation services.

c) THE LEGISLATIVE DEBATE

The Center at this point, decided to bypass the bureaucracy and take its case directly to the political level.

A meeting was arranged with the Minister at which time the Center Board made a submission and funding request direct to the Minister. The Center also began to mount its support among Calgary M.L.A.'s, local political figures and the general public. This resulted in a number of petitions being circulated. These petitions were presented to Mr. Ron Ghitter, a Calgary lawyer, involved in the initiation of the Center and now a Calgary M.L.A. and member of the government caucus. He tabled the petitions with several thousand names on them in the legislature. Considerable debate followed in the legislature and in the budget allocations committee, over funding to the Center and A.A.D.A.C.'s policies in related areas. The subcommittee hearings alone on A.A.D.A.C. estimates occupied three evenings and produced 140 pages of transcript. As a result of these discussions, the Executive Director of A.A.D.A.C. agreed that some aspects of the Center's activities were related to A.A.D.A.C.'s mandate. A portion, 20% was agreed on and it was further agreed that Mr. Anthony would recommend to his board that this amount be granted to the Center. The board eventually concurred in this recommendation.

d) THE MINISTER'S COMMITMENT

During the legislative debate and in other political settings surrounding this controversy, the Minister made two commitments. First, to provide a grant of \$16,000 to the Center. This was to be taken from the estimates of the Department. From information provided, it would appear that the grant agreed to by A.A.D.A.C. was interpreted by the Minister as the same commitment made by himself and that this money will not come from the A.A.D.A.C. budget but from his departmental budget as indicated above.

The second commitment was to have an independent evaluation of the Center's program undertaken before a final decision was taken on A.A.D.A.C. funding for the future. That report was to be tabled in the legislature during the 1975 legislative session.

On this basis, the Minister asked his staff to locate an evaluator who would be competent to carry out the evaluation. Two conditions were specified; first, the evaluator should have no interest in or connection with either the Center or the Provincial Government. Second, if possible the evaluator should come from outside the province of Alberta. The terms of reference given the evaluator were, a) to carry out an evaluation of the programs and activities of the center and the results achieved by the Center, b) to assess the services of the Center in relation to other service organizations in Calgary to determine possible areas of overlap or duplication of service, c) to evaluate the goals and programs of the Center in relationship to the respective mandates of A.A.D.A.C. and preventative Social Services.

SECTION II THE EVALUATION PLAN

I INTRODUCTION

As indicated in the Introductory Section of this report, several earlier attempts at evaluation had been undertaken. The purpose of these evaluations appears to have been to gather information to help determine whether A.A.D.A.C. should continue to fund the Center. These evaluation attempts as a result were suspect and led to considerable controversy in the Legislature when the decision was made to discontinue funding for the Center. As a result, the Minister made a commitment to provide the Center with some interim financing for the fiscal year 1974-75 and to commission an independent evaluation before finalizing the decision on future funding beyond the current fiscal year.

The evaluator was contacted by departmental officials in late August and asked if he would be interested in undertaking such an evaluation. A meeting was arranged with the Minister and the Deputy Minister, in early October to discuss the matter of an evaluation in detail. It was agreed at that meeting that the evaluator would submit a formal proposal by November 1, 1974. This proposal was considered by departmental officials and the Minister. The evaluator was informed in late November that the proposal was being accepted. The evaluator began the work on the evaluation in early December.

II PURPOSE OF THE EVALUATION

The evaluation had three basic purposes:

1. To determine the extent to which the drug information center had or had not accomplished the goals and objectives it had set out.
2. To assess the results of the experience with a view to making recommendations on the future of the program including whether it should be continued, its possible focus and direction, needed adjustments to goals, program content, and implementation procedures, etc.

V THE EVALUATION METHODOLOGY

The gathering of information was to be carried out as follows:

a) Service Users

Personal interviews with a random sample of 100 service users if possible, to determine their views of the services which they received. (See schedule of questions Appendix A)

b) General public

A telephone survey of 200 homes in Calgary, selected at random from the telephone directory. The purpose of this survey was to determine their knowledge of the Drug Information Center and its services and other drug oriented service resources. (See Appendix B - Telephone Questionnaire).

c) The Health and Social Service Delivery System

Personal interviews with those staff people who have been the primary contact people, at the working level. The purpose of these interviews was to determine the relationship of service organizations to the Center, to elicit their views of the Center and its services, and to explore possible areas of overlap.

d) Staff and Volunteers

Personal interviews to elicit from them, information about their particular area of service, and their knowledge of related matters such as the drug information program of the Center.

e) Groups Using the Drug Education Services

A sample of ten groups to be interviewed with whom the Center had conducted speaking engagements or seminars to determine if they found this program helpful and if so how.

f) Records

An examination of records of the drug information Center to determine the extent and nature of activities, trends in service activities and the nature of the population served. Where records from other services are available, comparisons will be made to determine the extent of duplication and overlap if any.

g) Information Services

An examination of the library material gathered by the Center to determine whether drug information is current, unbiased and complete. Other local sources of information were also to be examined and compared with that of the Center. The library services also were to be examined for evidence of how extensively used, when used, and the nature of that use.

h) The Volunteers and The Training Program

A random sample of volunteers no longer with the Center were to be interviewed to obtain their views on the Center's program and their involvement. A group workshop, for similar purposes, was to be conducted with present volunteers. In addition, the training program itself would be studied by direct observation, by examination of records and by obtaining the views of past participants in the program.

i) Spin Off Programs

A number of new services and programs have resulted from Center efforts to respond to the long term treatment needs of persons experiencing drug problems and to fill other service gaps. Staff of these programs were to be interviewed and records examined to determine the usefulness of these services, their relationship to Center goals, and their relationship to other available services.

j) Alberta Government Goals and Objectives

The services and programs of the Center were also to be examined in relation to the mandate and objectives of Provincial Government agencies including the department and A.A.D.A.C. The purpose of this examination was to determine

the relationship between the Center programs and Government programs, whether the Center programs compliment or duplicate Government programs, and whether the programs of the Center are sufficiently related to and supportive of the Government's objectives and efforts in the general area of drug education and rehabilitation to warrant continued government financial support for the Center, either directly or indirectly through its arrangements with the City of Calgary for funding social service programs.

VI ASSESSING EVALUATION FINDINGS

The results of the telephone questionnaires were to be tabulated and used to assess specific objectives and activities of the Center. They are compared with information obtained from other sources regarding the same activities. The results of the interviews conducted with service users were tabulated, compared against other information gathered and presented in both narrative and statistical form in the report.

The results of interviews with community officials and staff of other agencies have all been summarized and compared to each other. They are evaluated in terms of their relevance to the objectives of the Center being measured and in terms of their relevance to other factors being examined as part of the evaluation. Since responses from participants interviewed varied considerably, those responses occurring with regularity are summarized and presented in the report. Those responses occurring infrequently are only included if they have an important relationship to a particular area of the evaluation or if the deviation in the response is important in terms of the conclusions drawn.

Data for the background of the Center program and for the description of the program itself came from records and reports and was supplemented by personal interviews. In addition, where program records and statistics were available, which had a bearing on program results, this data was compared to other data gathered to validate the various views presented by participants or to determine where there were significant deviations and hence, contradictions between what various participants perceived and the actual facts as shown by recorded data.

SECTION III THE CALGARY DRUG ADVISORY SOCIETY AND THE DRUG INFORMATION CENTER

I HISTORY OF THE FORMATION OF THE DRUG INFORMATION CENTER

A) HISTORY

In its early progress reports, the Drug Information Center has chronicled its initial formation.

In October, 1969, Jack Colclough, University of Calgary United Church Chaplain, at the request of the Inter-Faith Committee, called a meeting of people in the City of Calgary who were concerned about the problem of drug misuse.

The first meeting was attended by representatives of the Canadian Mental Health Association; Preventive Social Services; the John Howard Society; Counselling Services at Mount Royal College, Southern Alberta Institute of Technology, and the Calgary Public School Board; University of Calgary Health Services and the Department of Psychology; the Calgary Youth Aid Society; the Department of Youth; and the Division of Alcoholism.

The meeting focused around the general topic of drugs and youth. Questions were asked about what the drug problem was and why it existed; what knowledge was available on the effects of drug use; what was being done in the City to educate people and help drug users; and what should be done in the areas of research, education, prevention, and treatment.

During the discussion, it was pointed out that no agency in Calgary was then giving factual, unbiased information on drugs. It also appeared that the negative attitudes on the part of some of the existing agencies which dealt with youthful drug users were creating problems for these clients.

After discussion, it was felt that the primary need at that time in Calgary was to establish an emergency hot-line for drug crises. The secondary need was to co-ordinate all programs which were aimed at drug education and treatment of drug associated problems.

As a result of this meeting, the Canadian Mental Health Association agreed to take on the responsibility for co-ordinating drug programs in Calgary and established the Co-ordinating Council on Drug Information, using as resources the people who attended the first meeting.

By the second meeting, about 40 different groups had been heard from, who were concerned with drug problems. Many of the groups felt that such problems were moral issues and should be treated as such. It was the feeling of the Co-ordinating Council, however, that in order to reach the people who were using drugs, they would have to avoid the use of scare tactics and anything which appeared to be based on moral issues rather than fact.

B) ADMINISTRATIVE STRUCTURE

In December, 1970, the administrative organization was altered. The Calgary Drug Advisory Society was incorporated under the Society's Act. Hence the Drug Information Center was no longer associated with the Alcohol and Drug Education Association. The Drug Advisory Council and Professional Advisory Committee were combined to form the membership of the new Calgary Drug Advisory Society.

The Council concentrated for a time on developing a concept of a crisis center which would meet the needs of the City. They started to make arrangements to set up such a Center in co-operation with the Psychiatric Unit of the Holy Cross Hospital.

At this time, the Calgary and Region Mental Health Planning Council had decided to set up a task force on drugs to discover the needs for this region. It was suggested to the Co-ordinating Council that the Planning Council be approached to see if they could use the support of the members of the Co-ordinating Council. Because of their past work, the members of the Co-ordinating Council were in fact used as a basis for the Drug Task Force.

The Drug Task Force set up three study groups to study a philosophy for the treatment of drug associated problems, the needs for educational services, and the development of a drug crisis center.

At this point in time, the Mayor of Calgary set up the Executive Committee, consisting of the Minister of Health, the Mayor, and the Chairmen of the Public and Separate School Boards. The purpose of this committee was to initiate and fund local drug programs.

Three different groups were interested in helping to set up a crisis center: the Division of Alcoholism, the Alcohol and Drug Education Association, and an independent citizen's group. The Task Force decided to accept briefs from each of the three groups and to choose the one which seemed to be most appropriate in terms of the Task Force's general philosophy. None of the briefs were accepted as they stood, but it was decided that the Alcohol and Drug Education Association should be accepted as a vehicle for funding, and that the original concept of the Co-ordinating Council be redesigned in the light of this fact.

This was done and was accepted by the Minister of Health when forwarded by the Planning Council. The concept of the Center as it now stood involved a program with three services: Information and Education, Crisis Intervention, and Research.

Don Bruce was seconded from the Division of Alcoholism to act as Director of the Drug Information Center, and Jack Oakey was seconded from the Alcohol and Drug Education Association to act as Assistant Director.

The final structural design was this:

CABINET PROVINCIAL GOVERNMENT	
MINISTER OF HEALTH	
EXECUTIVE COMMITTEE (Municipal Government)	
CALGARY & REGION MENTAL HEALTH PLANNING COUNCIL	
DRUG TASK FORCE	
DRUG ADVISORY COUNCIL	
DRUG INFORMATION CENTER	Professional Advisory Committee

The Drug Advisory Council (appointed by the Drug Task Force) was given the responsibility for policy decisions and program implementation. The Professional Advisory Committee consists of a group of representatives from different professions who advise on matters coming within their field.

C) GOALS OF THE CALGARY DRUG ADVISORY SOCIETY

The goals of the Calgary Drug Advisory Society as laid out in the Task Force Papers of the Society can be summarized as follows:

1. to reduce public fear of the problems related to drug usage by reducing misunderstanding and ambiguity about non-medical drug usage.
2. to develop better communications between young drug users and their parents.
3. to create a united effort by the Calgary community to deal effectively with drug usage related problems.
4. to co-ordinate various relevant services in meeting and dealing with the immediate problems resulting from drug usage.
5. to provide required services not presently in existence to deal with the immediate problems related to drug usage.
6. to develop and/or co-ordinate long term programs aimed at prevention of drug usage related problems rather than simply crisis intervention programs.

D) OBJECTIVES OF THE ALBERTA GOVERNMENT

The objectives of the Alberta Government as stated in the publications of the Alberta Alcoholism and Drug Abuse Commission are as follows:

1. to co-ordinate, promote and provide to Alberta residents, goal oriented programs of education, prevention, rehabilitation and treatment as a response to publicly perceived problems associated with use and abuse of drugs, including alcohol.

2. to assume a leadership role by co-ordinating and supporting the activities of individuals, organizations and communities involved with problems associated with use and abuse of drugs, including alcohol, and by sponsoring innovative demonstration projects to expand knowledge of successful approaches to these problems.

II CHANGES IN OBJECTIVES

Even before the inception of the Drug Information service, changes were being made in its goals and priorities. The continually increasing pressure for a crisis intervention/treatment program resulting from a rapidly increasing number of young people encountering serious problems while under the influence of drugs, placed this type of service on the top of the priority list.

While the gathering of information on drug related problems and the effects of non-medical drug usage remained a high priority of the Society, available funds did not allow this to be undertaken on the scope originally envisaged. The Center proceeded, however, with the resources available to commence the information gathering process and to develop mechanisms for its dissemination. A twenty-four hour telephone information line was developed in conjunction with the crisis intervention unit and an ambitious speakers program was initiated.

These changes in priorities and emphasis of the Center's goals were clearly restated in their 1971 project report as follows:

a) Short Term Goals

(i) Youth-physical survival; then to make the individual as comfortable as possible to bring him (her) down if they are on a bad trip and generally assist them over the immediate crisis while attempting to delineate underlying problems. Also to supply accurate information and advice in all crisis situations.

(ii) Parents - to inform them about drugs so that they can be more rational and objective; to calm them down and to try to develop better communications between parents and their children.

b) Long Term Goals

(i) Youth - to educate and inform them about drugs and their effects; to offer counselling when required and to act as a referral agency.

(ii) Parents - to educate and inform them about drugs and their effects; to encourage continuing improved communication between parents and their children and when required, to offer counselling and make referrals to other agencies.

III CHANGES IN PROGRAM

With the emphasis on drug related crisis intervention the Center was established as both a crisis and information center. In order to serve the main target population, the drug user, it was decided that the Center must have a very specific image based on specific policies:

A) It must be easily accessible.

(i) Centrally located

(ii) Open 24 hours, 7 days a week.

B) It must ensure total client confidentiality through client anonymity if that was desired by the client. (Exceptions were made with run away juveniles).

C) It must be flexible and non-bureaucratic.

D) It must have a diversified volunteer staff.

(By age, sex, drug related experience, attitudes and qualifications).

E) It must be comfortable and non-institutional.

F) It must be open and receptive to any type of problem or crisis.

G) It must only make referrals with the client's consent or when the client's physical or emotional state do not allow him to offer that consent.

H) It must be willing to explore other alternatives when a client rejects a referral.

I) It must provide transportation to those clients who are incapable of coming to the Center on their own.

With this client-centered openness, it was not long before the Center found itself being called upon to relate to a much wider range of problems than those related to drug usage. Initially there was some resistance to this wider range of activities by the Center's staff, however, this role is now seen as the normal course of the Center's activities. Drug related problems presently represent a minority of the Center's activities.

IV PRESENT PROGRAM OF THE DRUG INFORMATION CENTER

A. PROBLEM AREAS IN THE DRUG INFORMATION CENTER RECORD KEEPING SYSTEM

In describing the overall scope of the operations of the Drug Information Center, heavy reliance was placed on the statistical records of the Center. While this created some problems of accuracy of information, it was fairly easy to identify areas and extent of inaccuracies, and therefore, develop an accurate overall picture of the Center's activities.

The statistical records of the Center are based on having staff and volunteers complete client information cards, samples of which are contained in "Appendix C". Prior to August 1973, information was gathered on a preprinted form. Data card A was introduced in August 1973 and used until early 1975. Card B is presently being introduced.

With the change in the data collection system in August 1973, it was possible to derive more useful cross tabulations than could be made with the original system. As a result, however, it is not possible to compare some categories of data gathered after August 1973 with the period prior to that date. Where this problem exists it will be indicated.

The data gathering procedure creates the following specific problems:

- 1) It is dependent on the staff and volunteers filling in the cards accurately and completely.
- 2) The categories in which the data is gathered is geared to the internal needs of the Center and it is, therefore, difficult in many areas to compare the activities of the Center to other similar programs.

The staff of the Center is very aware of the former problem and has made a consistent effort to have the volunteer staff maintain accurate and consistent records.

There are however several impediments to this process:

- 1) Record keeping is a problem for any organization.
- 2) When dealing with human crises it is difficult to stress the importance of taking time to fill in the required forms.
- 3) This problem is accentuated in an agency which stresses informality.
- 4) This problem is further accentuated when the agency is dependent on a large volunteer force.

Despite the aforementioned areas, the data collection system is reasonably accurate with three areas of exception.

- 1) As part of its overall strategy, the Center strives to maintain an image of openness and accessibility. As a result, it encourages people to drop in whether or not they are seeking the services of the agency. Many potential clients use this openness to drop in and survey the physical facilities before coming back for assistance from the Center. These "drop-ins" are not usually recorded unless they are specifically seeking assistance. It is in many cases difficult to determine this type of drop-in as many of them will casually ask for information at the same time.

For example, a person may drop in and ask for the location of a specific agency. Another may drop in and ask where he can obtain specific help and be referred to that same agency. The former case would probably not be recorded whereas the latter would be. As a result, drop-in requests for information are largely underestimated in the Center's statistics.

2) The Center has a social worker who is seconded from the Federation of Family Services Agencies. He maintains separate statistics (which will be presented later) from those of the Center. To a large degree, his statistics are not included in the overall statistics of the agency. As he handles a large portion of the Center's counselling activities, the statistics for counselling services for the Center are also largely underestimated.

3) The Center does not have an adequate system of recording referrals to and from other agencies.

Aside from the foregoing areas, the statistics of the Center are by and large complete and accurate within a 10% margin of error attributable to the previously mentioned problem of relying on a large volunteer force to take the necessary time to complete the client information forms.

In all of these areas, the result would be that the statistics underestimate the Center's activities.

B. EVALUATION OF THE DRUG INFORMATION CENTER'S RECORD KEEPING SYSTEM

1) The Center has carried out several self evaluations of their operations by having a staff member record the Center's activities for a one week period at a time and compare their results to those shown on the cards. A sample of these self evaluations produced the following

results:	Shift	<u>8AM-6PM</u>	<u>6PM-12PM</u>	<u>12PM-8AM</u>	<u>Total</u>
Results from Evaluation		65	56	18	139
Results from cards		47	36	12	95
Expected results from Statistics		43.3	30.2	28.1	102.6

The discrepancy between the evaluation and the cards is largely attributable to casual drop-ins as is predictable from the earlier observation relating to volunteers not rigorously recording these clients unless they indicate they are seeking help. As a result, the evaluator recorded 68 phone calls and 70 drop-ins when in fact, the cards showed 66 phone calls, but only 29 drop-ins.

The demographic information and the information regarding the services required (ie. information, crisis, etc.) were statistically comparable on all three sets of figures.

During 1973 both the Alberta Alcohol and Drug Abuse Commission (AADAC) and the Non-Medical Use of Drugs Commission (NMUD) funded independent evaluations of the Center. Both of these studies contained a component of recording the Center's activities. The A.A.D.A.C. study contained 95 hours (56.6% of a week) of observation and the N.M.U.D. contained 70 hours (41.7% of a week) of observation. The A.A.D.A.C. study recorded 69 client contacts and the N.M.U.D. study recorded 74. The Center's statistics project an expectancy of 58.1 and 42.8 contacts respectively. Again the difference is almost completely attributable to the two studies recording a greater number of drop-ins than the statistics would suggest. The results of these two studies are recorded on Table I, Page 25.

Since the categories of activity are somewhat different than those used by the Center, a detailed comparison is not possible, however, the overall ranking of the studies are similar to the rankings suggested by the Center's statistics with the exception of the large number of drop-ins recorded by the two studies.

TABLE I
CATEGORIZED ACTIVITIES OF D.I.C. OBSERVED BY
A.A.D.A.C. AND N.M.U.D.

Activity Category	Observers			
	A.A.D.A.C. (95 hrs)		N.M.U.D. (70 hrs.)	
	Frequency	Rank	Frequency	Rank
A. New Drop-ins	21	2	30	1
B. Regular Drop-ins	27	1	21	2
C. Drug information (Phone)	12	3	17	3
D. Crisis Clients	4	4	7	4
E. Counselling Calls	3	5	5	5.5
F. Overnight Drop-ins	2	6	5	5.5
G. Meetings of Volunteers	1	7	2	7
H. Maintenance	5.25 hrs.		15 hrs.	

C. SCOPE OF DRUG INFORMATION CENTER PROGRAM

The Center has maintained detailed records of their activities since July 1971. In the 39 month period to September 30, 1974, they had 17,347 client contacts, for an average of 444.6 per month. Some of these contacts included more than one person, and therefore, their number of actual client contacts was somewhere in excess of 21,000. The trend of client contacts is depicted in the graph on Figure 1, Appendix D. Of these contacts, a small percentage were people who made numerous contacts for ongoing counselling and support services over a prolonged period of time. Another slightly larger percentage were people who receive regular counselling over a short period of time. 50.7% of the contacts, or 10,647 were seeking the services of the Center for the first time in six months. This would suggest that the total client population of the Center has been in excess of 8,000 different people, or upwards of 200 people per month.

The services which the Center extends to its client population can be described in four different categories.

1) Information Services

The Center maintains a 24 hour information service. This service would include requests for information related directly to drug usage or abuse as well as a wide variety of other types of information. Much of the other information is related to locating resources, particularly those resources sought after by youth. The Center catalogues and provides informal critiques on all of the social service agencies in Calgary, as well as information and accommodations, vocational opportunities, recreational and educational activities. Requests for this type of service number 6617 for the 39 month period or an average of 169.5 per month. The trend of this type of client contact is depicted in the graph in Figure 2, Appendix D. A breakdown of the types of drug related contacts is depicted in figures 6 and 7, Appendix D. These figures do not include organized speaking engagements or information supplied through the street worker program and co-ordination program.

Speakers Program

The Center also conducts a speakers program in which they will provide speakers to a wide variety of groups and organizations. Initially the speaking topics were confined strictly to information relating to drug usage and associated problems. Over the years, this has come to include information on the Center and its activities, and in the past year, the emphasis has been on this type of program. Detailed records of speaking engagements were available for the 22 month period from September 1973 to June 1974. During this period, the Center conducted 186 speaking engagements to a total audience of about 4520, or an average of 24.3 people per engagement. Speaking engagements were conducted for such diverse groups as schools, social service professional associations, workers, housewives, service clubs, youth clubs, university classes, police, church groups, parents, social agencies, hospital patients, prison inmates and other crisis intervention agencies.

Street Program

The Center maintains a street worker to keep in close contact with the "drug scene" in Calgary. This person provides a two way information service, both to the Center and to other agencies involved in drug related activities. The information which he gathers is largely related to the types, quality and quantity of drugs that are being made available in Calgary. This service allows the Center and other related agencies to prepare themselves to respond quickly to crises arising from periodically available overly strong drugs or drugs which are cut with abnormal toxic substances, or when abnormal amounts of a specific drug is being made available.

Co-ordination Program

The Center has attempted to play both an information and co-ordination role in respect to drug related programs and youth related programs which are made available in Calgary by various voluntary and government agencies. In this area, the Center has been most active in co-ordinating summer programs for youth.

2) CRISIS SERVICES

The Center operates a 24 hour crisis intervention service. The object of this program is to intervene in a crisis situation at the earliest possible opportunity on the assumption that early intervention can minimize the negative effects of the crisis on the individual as well as minimizing the demands which the crisis would place on the social service delivery system. In other words, the aim is to get to the problem before it has a chance to grow. This assumption is not only true of a traumatic drug experience which will have greater negative long-term emotional results the longer it continues unassisted, but it is also generally true of untreated medical problems or unassisted family and personal problems and emotional problems. In this area, the Center was initially designed to, and in fact did, respond largely to crisis related to non-medical drug usage. Soon after its inception, however, the Center, like any other crisis

intervention program, found that it was being called upon to intervene in a wider and wider scope of crisis problems. At present, drug related crises make up only about 40% of the total crises in which the Center is called upon to intervene. The Center defines a crisis as any situation with which a person is unable to cope unassisted at the present time. Most crises with which the Center deals involve a component of emotional problems.

In total the Center records show a total of 2440 crisis interventions over the 39 month period for an average of 62.6 per month. The trend of crisis intervention activity is depicted in Figure 3, Appendix D. A breakdown of drug related activity is depicted in Figures 6 and 7, Appendix D.

3) COUNSELLING SERVICES

There is an overlap in the lines that divide information programs from counselling programs. The main activity of the Center is information. The Center is, however, prepared to provide follow-up emotional support and in a limited number of cases, provides long term psychotherapeutic services. The volunteer staff only do show very limited counselling, and then under close supervision. The Center does, however, have one person whose prime responsibility is counselling. He is a social worker, seconded from the Federation of Family Services. As indicated on Figure 4, Appendix D, the general counselling activities play a small but steady part in the Center's activities. However, the social worker's counselling activities are substantially more significant in terms of total client contacts. Table 2 depicts the scope of counselling activities of the social worker for the 12 month period from September 1, 1973 to August 31, 1974 for which detailed figures were available.

TABLE 2

CLIENT COUNSELLING ACTIVITIES OF THE SOCIAL WORKER

	1973				1974							
	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Phone interviews	20	12	28	20	35	28	30	28	20	15	28	36
House visits												
# of sessions	6	4	8	10	7	8	11	9	4	6	7	5
# of people involved	10	7	14	14	11	11	16	16	6	8	11	7
Office interviews												
# of sessions	19	34	44	27	37	31	43	33	21	17	33	35
# of people involved	24	43	59	34	44	38	48	39	27	19	36	35
Group sessions							6	8	5	3	5	2
# of people involved					83	47	59	96	64	38	54	37
Total number of client contacts	44	50	80	57	152	124	143	166	109	76	122	109

4) OTHER SERVICES

For statistical purposes all other activities have been grouped together. The scope and trend of these other services is depicted on Figure 5, Appendix D. Since the change in data gathering procedures August 1, 1973, a more detailed breakdown of other services has been recorded. This breakdown is depicted in Table 3 on Page 30.

TABLE 3
TYPES OF SERVICES PROVIDED

<u>Type of Service</u>	<u>Portion of total Contacts</u>
Information	28.7%
Talk	19.3
Counselling	16.7
Drop-Ins	11.8
Crisis	7.1
Referral	3.7
First Aid	1.3
Overnight Accommodations	1.2
Other	10.2
Total	100.0%

Although these figures provide a greater breakdown of the Center's activities, it is difficult to assess this breakdown, as many of these activities tend to overlap based on the subjective assessment of the volunteer. For example, experienced volunteers have a greater tendency to see themselves as counsellors and therefore would tend to show an emotionally supportive conversation with a client as a counselling call, whereas a less experienced volunteer would list the contact under talk or a drop-in. Most of the contacts in the latter two categories appear to come from clients suffering from loneliness and seeking emotionally supportive contact from the volunteer. The categories therefore, tend to blur together and the increase in overall other activities shown on Figure 5, Appendix D might in fact be more a function of record keeping categories than of actual activities.

The category referrals is confined to situations in which no crisis is involved and the volunteer refers the client either to the Center's staff or to an external agency without further involvement. Many of the contacts in other categories therefore, also involve referrals. The Center's data is insufficient to determine the extent or nature of these referrals.

The category overnight accommodation, while only representing a very small percentage of the total, would now be virtually eliminated. The Center does not provide overnight accommodation unless the client is experiencing difficulty from drug intoxication. Most of these contacts would be recorded under the crisis category.

D. MODE OF CONTACT BY THE DRUG CRISIS INFORMATION
CENTER CLIENTELE

Although the Center has a streetworker, this is primarily not an outreach program to provide out-service counselling and crisis intervention. The Center does, however, provide outreach workers to local events where heavy drug usage is likely. For example, the Center sent workers to local rock concerts.

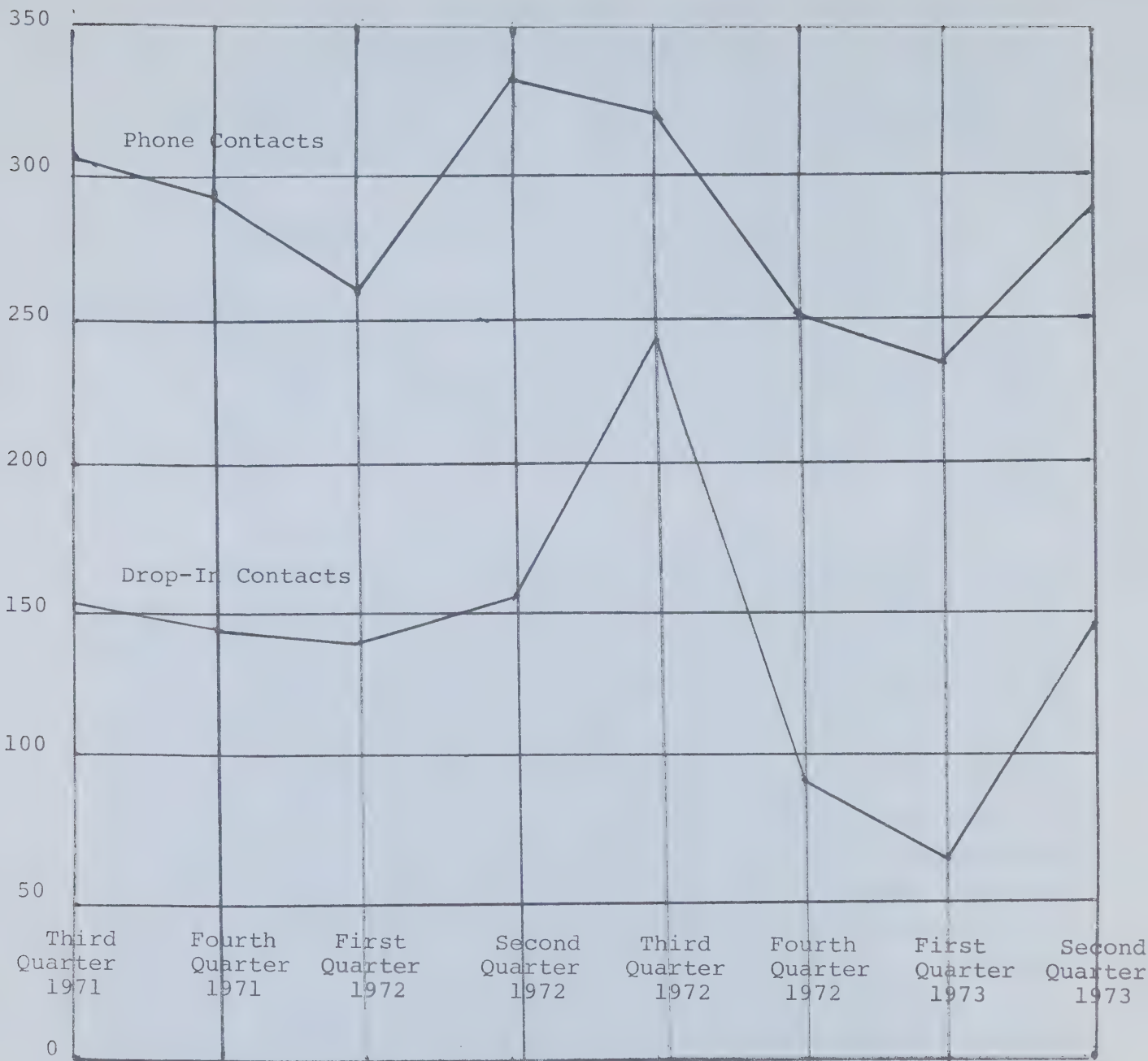
Most of the clientele of the Center hear about the Center by word of mouth. Speaking engagements have played a role in providing exposure for the Center, however, the extent to which this exposure is translated into clientele is not known. The Center also does limited advertising. Exposure in the public media has also resulted in some people seeking the Center's services. This is most apparent by the huge demands made on the Center's resources in April 1974 immediately after the Center had been involved in public controversy in March of 1974. In that one month, the Center had 852 client contacts, 234 more than the next highest month in July 1972, and almost twice the average monthly contact.

Most clients seek out the services of the Center rather than vice-versa. Clients can contact the Center either by telephone or by coming down to the Center. Phone-in clients are often encouraged to come down to the Center, or in crisis situations, workers are sent out to the location of the crisis.

The mode of initial contact was recorded by the Center from August 1971 to June 1973. These records are depicted in Figure 6 on Page 32.

FIGURE 6

FREQUENCY OF PHONE AND DROP-IN CONTACTS



The change in data collection procedures in July 1973 makes comparisons with the more recent period difficult. During the period from August 1971 to June 1973 the ratio of phone calls to drop-ins was fairly steadily maintained at 2:1 and there is no reason to believe that this ratio has not continued through to the present.

E. TWENTY-FOUR HOUR SERVICE

The Center maintains a twenty-four hour service. Initially, the doors were open twenty-four hours a day for drop-in clients, however, some difficulties with the security of the late night volunteers has resulted in this practice being discontinued between the hours of 12 midnight and 6:30 A.M. Twenty-four hour phone service is maintained and the Center's staff are on rotating twenty-four hour standby shifts for crisis intervention. The distribution of contacts for the three shifts is depicted in Figure 7. Page 34.

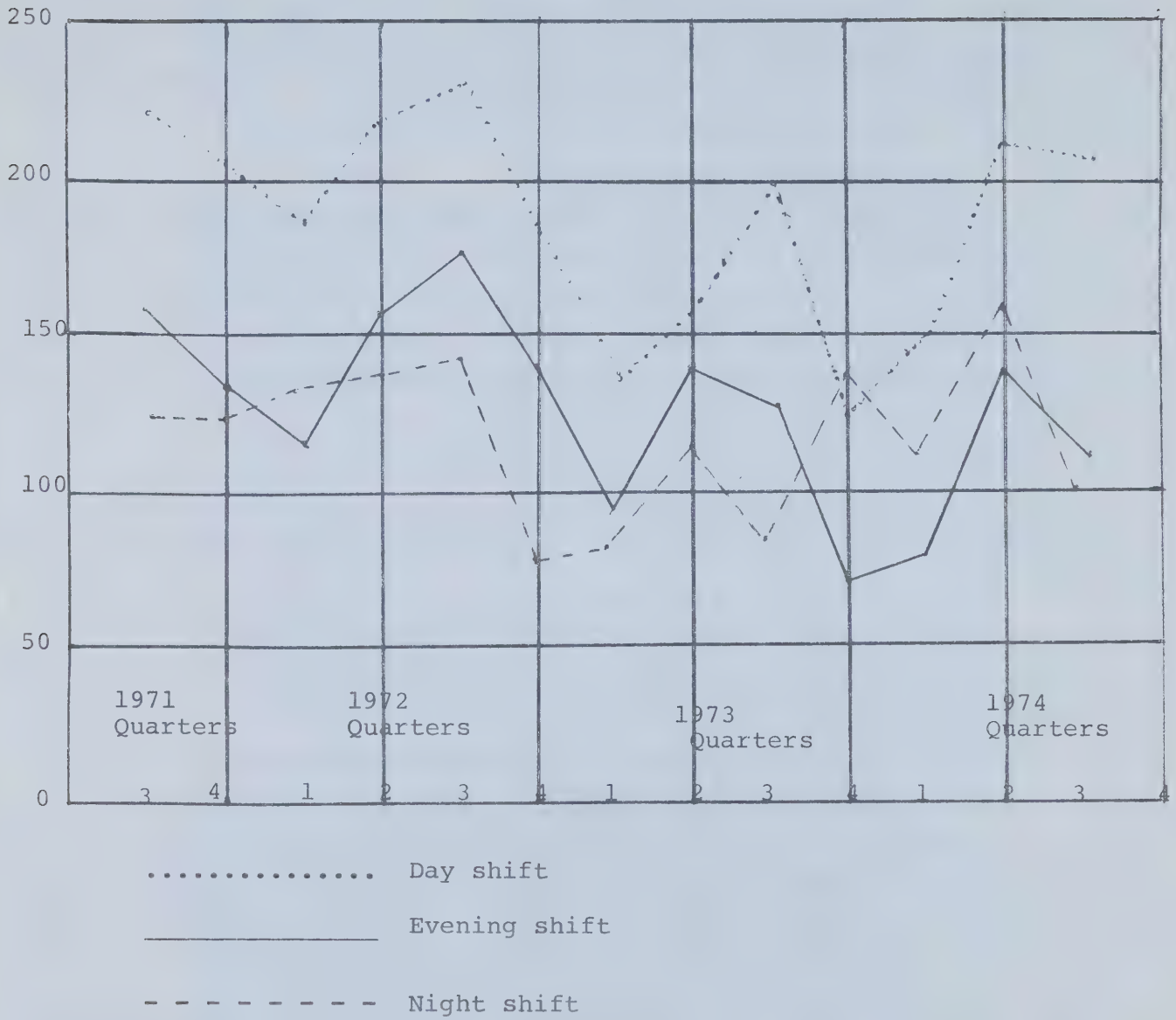
While day time contacts represent a slightly larger percentage of the Center's overall contacts, both the evening and night contacts represent a significant portion of the Center's activities.

F. EXTENT AND NATURE OF DRUGS DEALT WITH BY THE DRUG INFORMATION CENTER

While the Center was created primarily to deal with drug related problems, since its inception, the Center has been called on to deal with other sorts of problems than those related to drug usage. Some of these have a component of drug usage, but the drug component is not the prime problem and in some cases not even a significant problem. In other cases, the Center has been called upon to deal with a drug related problem of an individual, but having dealt with the drug related problem, the client has continued to use the Center's resources for dealing with other problems. In some instances, there is no drug usage involved at all. Non drug related problems have become an increasingly larger portion of the Center's activities. During the period from August 1973 to September 1974, drug related problems represented 43.1% of the client contacts of the Center.

FIGURE 7

FREQUENCY OF CLIENT CONTACTS ON EACH SHIFT



The Center has been involved in servicing problems related to a wide variety of divergent types of drugs. The extent to which each type of drug has been involved during the period between August 1973 to September 1974 is presented in Table 4.

TABLE 4

PERCENTAGE OF EACH TYPE OF DRUG INVOLVED IN PROBLEMS
PRESENTED TO THE DRUG INFORMATION CENTER

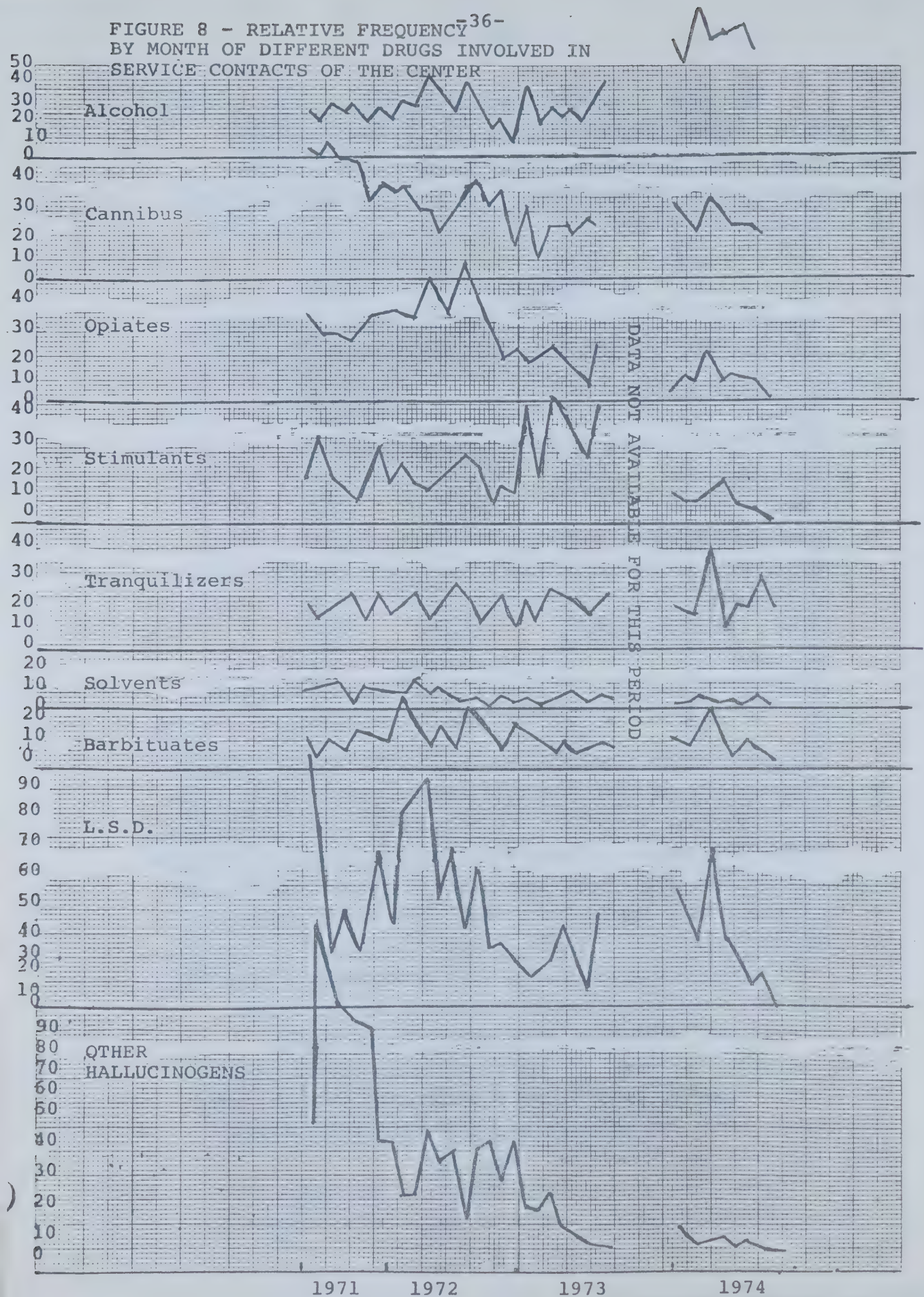
<u>Type of Drug Involved</u>	<u>Percentage</u>
Alcohol	12.8%
LSD	8.0
Cannibus	6.7
Tranquilizers	5.5
Barbituates	2.7
Opiates	2.5
Stimulants	2.5
Other Hallucinogens	1.7
Solvents	.7
No Drugs	56.9

The involvement of different drugs in problems handled by the Center varies from month to month. There are a number of reasons for this variation. For example, the involvement of Cannibus is largely a function of street supply of the drug. Solvents, on the other hand, which are in steady supply, but not in popular use, appear in a small but steady percentage of the problems presented. L.S.D. varies partially as a function of quality of the drug available with abnormally strong drugs, and drugs cut with other toxics appearing on the street periodically and causing a large number of problems. While the trend of other hallucinogens also varies greatly, the overall trend is down sharply, mirroring the fact that less people today are willing to experiment with unknown drugs than was the case a few years ago.

The trend of the involvement of all drugs in problems presented to the Center is depicted in Figure 8,

Page 36.

FIGURE 8 - RELATIVE FREQUENCY³⁶⁻
BY MONTH OF DIFFERENT DRUGS INVOLVED IN
SERVICE CONTACTS OF THE CENTER



Likewise, the demands for different types of service placed on the Center varies with different types of drugs. Some drugs result in few crises, but create a large demand for information. Other drugs create crises and therefore a demand for those services. Others are more involved in problems requiring counselling. A breakdown of the relationship of different drugs to different services is presented Figure 9, Page 38.

G. POPULATION SERVED BY THE DRUG INFORMATION
CENTER

The records of the Center include some demographic information on the clientele seeking services of the Center. A breakdown of the Center's clientele by age is shown in Table 5.

TABLE 5
AGE BREAKDOWN OF DRUG INFORMATION CENTER CLIENTELE

Age Group	
Under 15 years	7.1%
15-20 years	56.5%
21-29 years	29.4%
Over 30	21.7

On an overall basis, the largest part of the Center's clientele are in the 15-20 year old group. This is the case with all types of services, however, the demands for crisis information has a much larger percentage from this age group in relationship to other age groups than is the case with other services of the Center. A comparison of the age groups seeking counselling and crisis intervention is presented in Figure 10, along with the trend of demands for the different services by different age groups. (Page 39)

Different age groups have presented problems involving different types of drugs. These differences are depicted in Figure 11, Page 40.

FIGURE 9

EXTENT TO WHICH DIFFERENT DRUGS ARE INVOLVED IN PROBLEMS

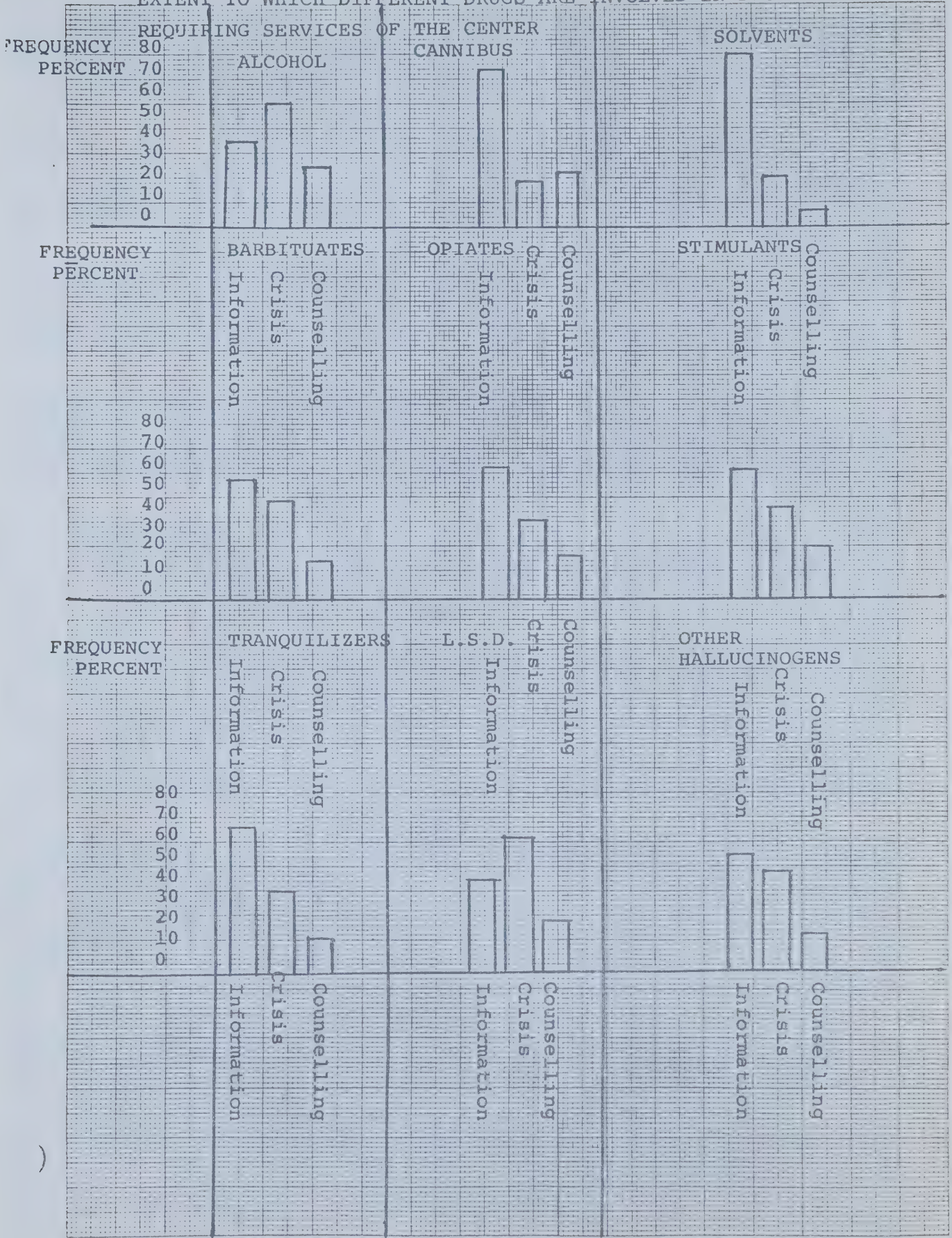


FIGURE 10

-39-

COMPARISON OF CRISIS CONTACTS TO COUNSELLING CONTACTS BY AGE GROUP

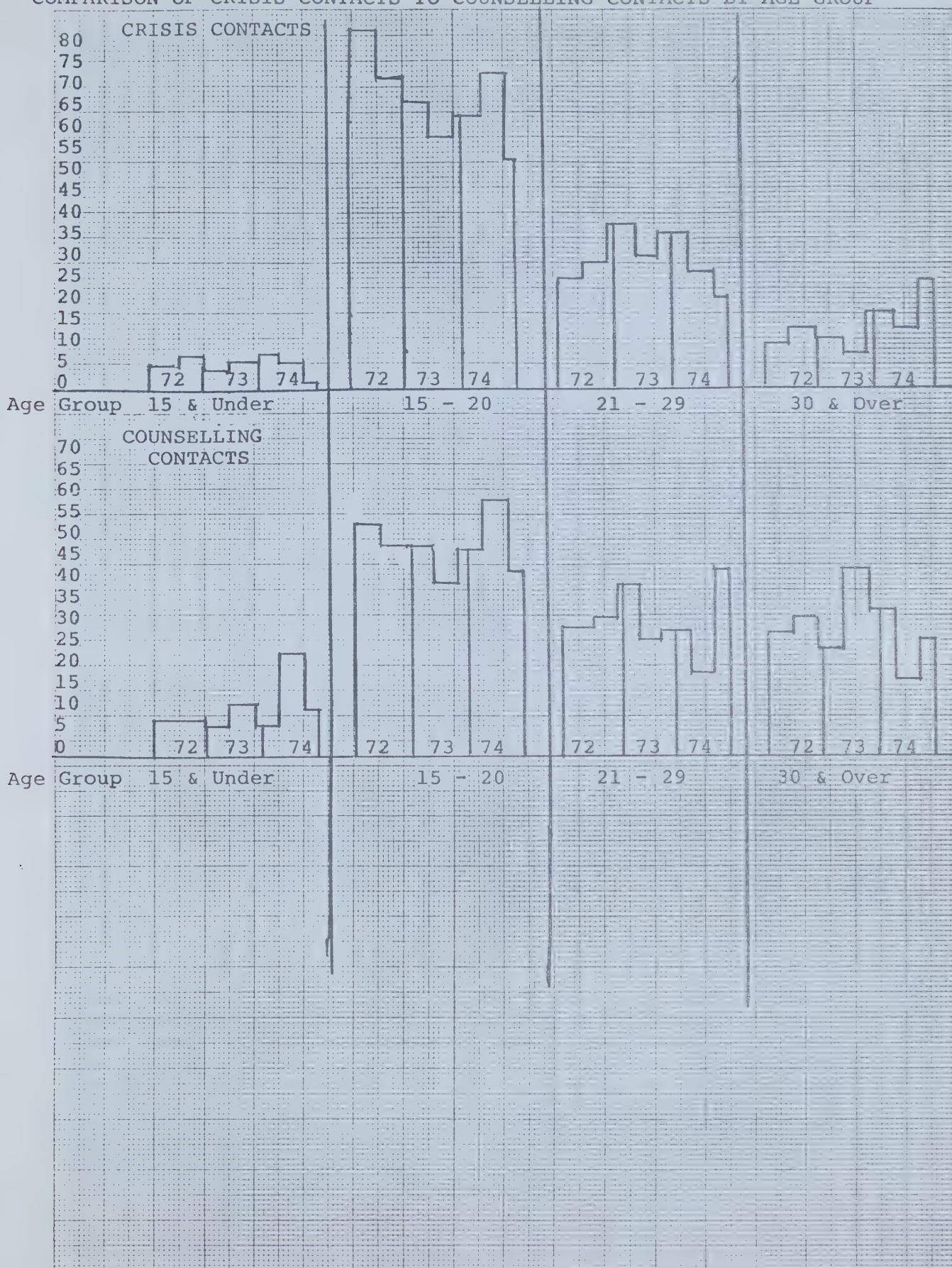
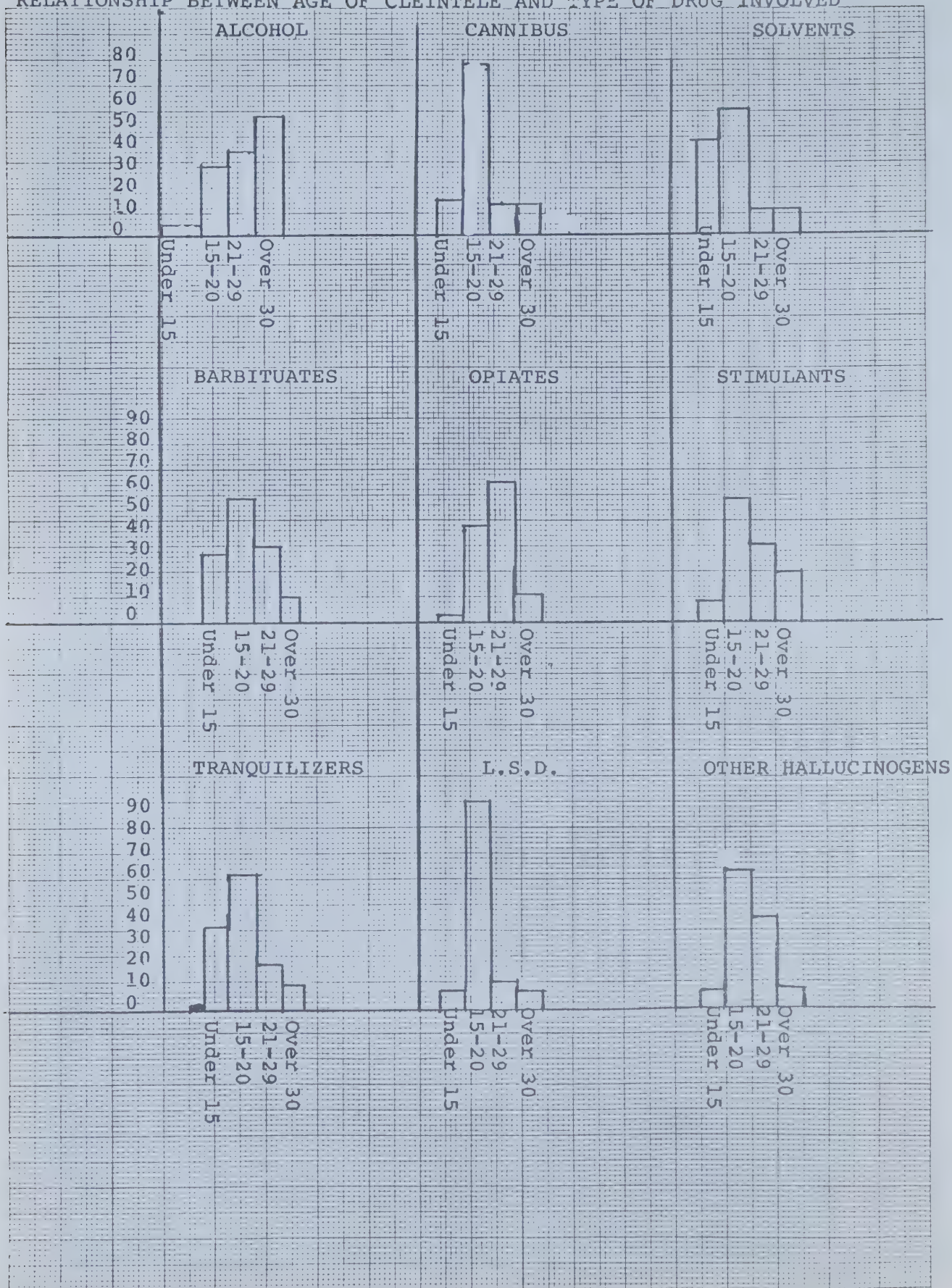


FIGURE 11

-40-

RELATIONSHIP BETWEEN AGE OF CLEINTELE AND TYPE OF DRUG INVOLVED



Of the clientele presenting problems in which no drugs are involved, they are distributed by age groups as represented in Table 6.

TABLE 6
RELATIONSHIP OF AGE GROUPS OF CLIENTELE TO PROBLEMS
WITH NO DRUG INVOLVEMENT

Age Group	
Under 15 years	5.9%
15 - 20 years	45.1%
21 - 29 years	29.6%
Over 30 years	19.4%

While half of the population served by the Center is youth under 21 years of age, the Center also focuses a portion of its activities at the parents of this population. Figure 12 reflects the overall relationship between the frequency of youth and parents seeking the services of the Center. Figure 13 reflects the demands for different types of services. (Figures 12 & 13, Page 42.)

While the demands by youth for information and crisis intervention services has decreased over the years, the demands for services by parents has been relatively steady since the inception of the Center. This is particularly significant in the areas of information and counselling services where parents represent a sizeable portion of the total clientele.

Of the Center's clientele, 24.7% are students, 31.4% are working and 44.9% are unemployed. During the winter months the percentage of clients who are unemployed has increased and during the summer months, the percentage who are students has increased. On an overall basis, however, these percentages have remained fairly constant from year to year.

FIGURE 12 - RELATIONSHIP BETWEEN

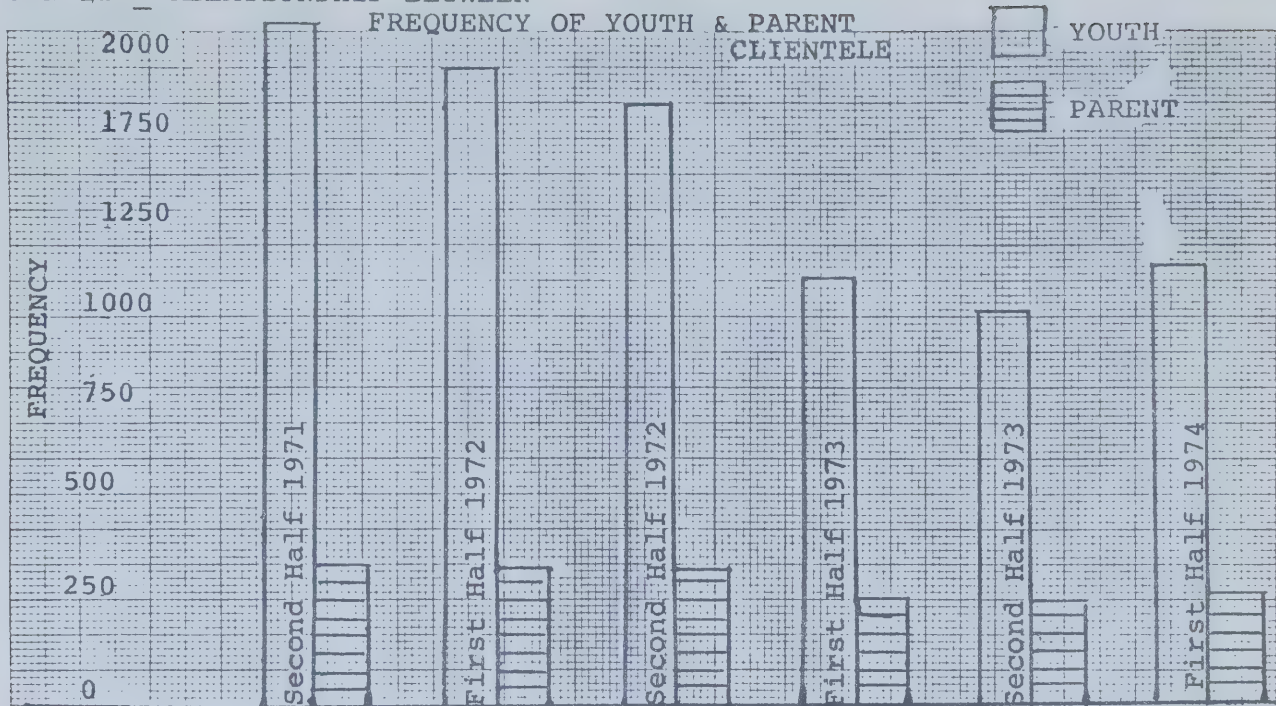
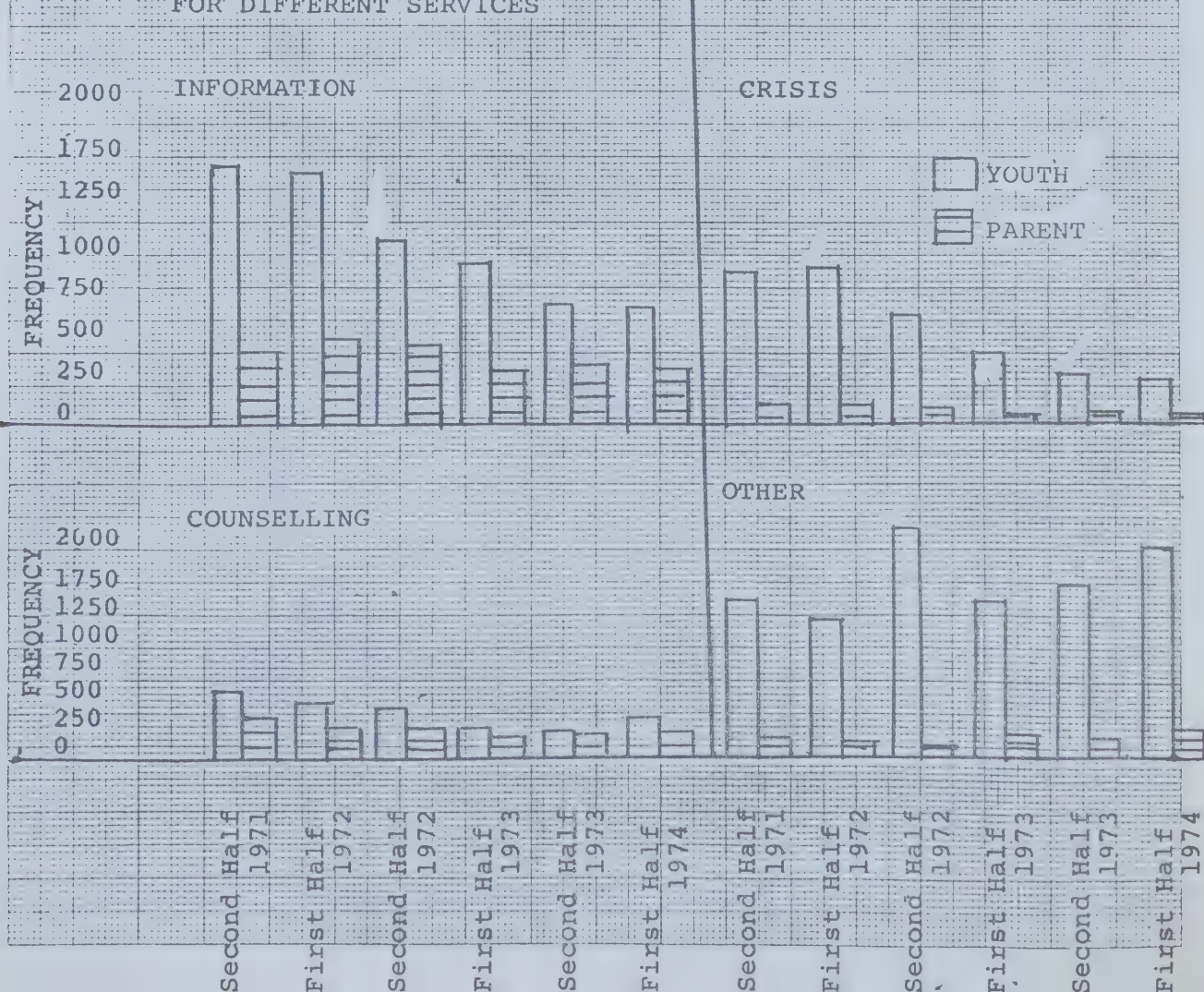


FIGURE 13 - BREAKDOWN OF FREQUENCY OF YOUTH AND PARENT CLIENTELE FOR DIFFERENT SERVICES



By sex, the Center's client population has been slightly more male, however, this is more true with crisis information services than with crisis intervention. Table 7 reflects the relationship between sex and counselling and crisis services.

TABLE 7
RELATIONSHIP OF SEX TO CRISIS AND COUNSELLING SERVICES

Crisis Intervention

Males 56.4%

Females 43.6%

Counselling

Males 50.6%

Females 49.4%

The majority of the Center's clientele are residents of Calgary. The remainder are almost evenly divided by out-of-town residents visiting Calgary and transients who are simply passing through. While the transient population increases dramatically during the summer months, the overall use of the Center's facilities also increases and therefore the proportion of transients to local residents has remained fairly constant. Table 8 depicts this relationship.

TABLE 8
FREQUENCY OF CLIENT CONTACTS BY LOCAL RESIDENTS,
VISITORS AND TRANSIENTS BETWEEN AUG. 1973 AND SEPT. 1974

<u>Status of Client</u>	<u>Frequency</u>
Calgary residents	4441
Out-of-town visitors	291
Transients	241

H. STAFFING

The Center operates with a staff of six full time and one part time employees. Their job descriptions are summarized as follows:

1) DIRECTOR

- Responsible for day to day management of the Center
- Responsible for general management of any other projects operated by the Calgary Drug Advisory Society.
- Responsible for staff recruiting, hiring and personnel management.
- Responsible for budgeting.
- Responsible for fund raising.
- Responsible for general relationships with other agencies.

2) SOCIAL WORKER

- Responsible for overall supervision of all counselling services.
- Handles a case load of counselling clients.
- Responsible for follow up on crisis contacts.
- Responsible for supervised referrals.
- Responsible for counselling component of volunteer training program.

3) VOLUNTEER CO-ORDINATOR

- Responsible for recruiting and selection of volunteers.
- Responsible for volunteer training program.
- Responsible for co-ordinating all aspects of volunteer program, including scheduling of volunteers, matching of inexperienced volunteers with required resources, and co-ordinating follow up work with clients.

4) STREET WORKER

- Carries a counselling case load both in and out of Center.
- Handles out-of-Center followup with clients.
- Responsible for keeping in touch with the "street scene" particularly as it relates to the availability and quality of non-medical drugs and patterns of usage.

5) PROGRAM CO-ORDINATOR

- Assists volunteer co-ordinator in volunteer program.
- Responsible for the co-ordination of speaking engagements.
- Responsible for the design of new programs.
- Responsible for co-ordinating "personal growth groups" held amongst both volunteers and clients.
- Responsible for public relations.
- The Center is in the process of eliminating

this position in favour of a crisis follow up worker.

6) SECRETARY/BOOKKEEPER

- Responsible for all office procedures and practices.
- Responsible for accounting for all funds and expenditures.
- Responsible for all secretarial and clerical functions.

7) PART-TIME INFORMATION CO-ORDINATOR

- Responsible for the collection and dissemination to staff of up-to-date information relating to drug usage.
- Responsible for ordering books, journals and pamphlets.
- Responsible for indexing and cataloging all incoming information.
- Responsible for pharmacology portion of volunteer training program.

I VOLUNTEER PROGRAM

The Center is staffed by a volunteer force of 45 to 60 people. There are two volunteers handling the incoming telephone lines. They work in three shifts covering each twenty-four hour period. Each volunteer is requested to work one shift per week.

Volunteers are selected from a wide range of demographic groupings. The main qualifications for selection of volunteers are personality and attitude. Maturity, empathy, openmindedness, stability and resourcefulness are the main characteristics sought after.

J FUTURE PLANS

The Calgary Drug Information Center is in the process of changing its name to "The Center". The old name will be retained and phone numbers will be listed under both names. This change of name reflects the intentions of the Center to broaden its client base and expand its crisis intervention and counselling activities in other than drug related problem areas. The staff of the Center feel that this change formally recognizes a change that has been taking place over the past several years. Less and less problems referred to the Center are related to drug usage. The staff feel that they have all along been dealing with a fairly wide age range of clientele and have been successful with clients from other socio-economic groups than the counter-culture. The Center also recognizes the importance of continuing to serve youth who still represent the greatest numbers of their clientele, and to maintain an open, non-bureaucratic service on the clients terms and therefore will also maintain that image and a phone listing under the old name.

K OTHER PROGRAMS OF THE CALGARY DRUG ADVISORY SOCIETY

Aside from operating the Drug Information Center, the Calgary Drug Advisory Society has entered into a number of other programs in order to achieve their goals. Most of these were temporary programs of the Society and not central to its ongoing operations.

1) THE ALTERNATIVES CENTER

From April 1, 1973 to March 31, 1974, the Society operated a center designed to provide a place where young people could get together and be given the attention and opportunities for self-development which they appeared to desire within an atmosphere which would suit their life style preferences. Activities were designed as an alternative to hard-drug usage. They involved creative art and the potential for human expression.

It is difficult to assess the impact of this program as it was discontinued after the one year funding grant from the Non-Medical Use of Drugs Directorate expired. Detailed records of clientele were not maintained.

2) HEROIN WITHDRAWAL

The Drug Information Center staff were involved with the Foothills Hospital in the selection procedures for a methadone withdrawal program for persons addicted to heroin. This function has since been taken over by another agency - The H.E.L.P. Society which operates a halfway house for recovering addicts.

3) TRANSIENT YOUTH PROGRAMS

Since 1970, all levels of government have been involved in providing a large number of services to transient youth. Rather than expand the number of these services, the Center staff confined their activities to co-ordinating the activities of these various programs as well as the programs of other agencies. These programs included medical services, a newspaper, hostel facilities, welfare services and information services. Detailed records

of the extent of these activities were not maintained as the role of the Center was co-ordination rather than implementation.

4) STUDENT PLACEMENT SERVICES

At one point, the Center was prepared to use its facilities as a practicum facility for psychology and social work students. While large numbers of such students have served as volunteers at the Center, with the exception of a few students from Mount Royal College, a formal practicum program has not been mounted. Several students have done practicums at "The House".

5) "THE HOUSE"

"The House" was a program started June, 1973 by the Calgary Drug Advisory Council. They initially described the program as follows: "a facility to provide a communal living situation for teens between the ages of 13 and 19. The House would have two live-in staff plus two relief staff and a part time Social Worker. The House would be geared for the sort of young person who is becoming increasingly common at the Center: he, or she, has dropped out of school, yet, because of age, lack of training or disinterest is not employed and probably currently unemployable. He has a history of behavioral or emotional problems and a family that is either disinterested, given up, or not a suitable place for him. Frequently, he has spent time simply 'living' on the street."

Since its inception, "The House" has moved more towards becoming a halfway house for teenagers who have been institutionalized due to emotional problems. This program continues as an ongoing project and will, therefore, be discussed in the evaluation section of this report.

SECTION IV EVALUATION FINDINGS ON THE IMPACT OF THE PROGRAM OF THE DRUG INFORMATION CENTER

I. INTRODUCTION

In accordance with the aforementioned methodology, the impact of the program of the Drug Information Center was examined against both the initial goals of the Calgary Drug Advisory Society and the goals as they were revised during the implementation and carrying out of the program of the Center.

One of the major factors resulting in a change of goals stemmed from the fact that initially the Calgary Drug Advisory Society defined the problem as one primarily related to drug usage. While the late sixties saw a rapid proliferation of non-medical drug usage, particularly by youth, this proliferation was accompanied by a larger social phenomena - the development of a counter-culture which rejected the values and normative mores of the existing society. Old values of self sacrifice, self control and delayed gratification were replaced by a drive for immediate hedonistic pleasure and self actualization. The non-medical use of drugs was very much a part of this counter-culture.

The non-medical use of drugs came to symbolize the counter-culture because so many aspects of drug usage typified the values of the counter-culture. The basis for drug usage was hedonistic pleasure seeking. Intoxication from drug usage was antithetical to a responsible attitude which provides the basis for a future oriented work ethic. Probably as important as any other factor, non-medical drug usage was, and still is, largely illegal and therefore formally flies in the face of the existing social value system. Also of major importance was the lack of knowledge about the effects of drug usage by the older generation which allowed the younger generation to see themselves as "experts" in relationship to the older generation in the area of drug usage.

While superficially, the latter might have been a fact, in the early stages of the proliferation of drug usage of

the mid and late 1960's, members of the younger generation were far from being experts on drug usage. While the dangers from drug usage might be minimal with some drugs in some situations, many drugs are extremely dangerous, and with a lack of detailed knowledge, the chance of precipitating a crisis situation through drug usage is greatly enhanced. As a result, the rapid proliferation of drug usage amongst an unsophisticated but defiant segment of the population created two major needs:

- 1) The need for wide dissemination of knowledge about non-medical drug usage and;
- 2) the need for programs to deal with immediate crises resulting from drug usage mishaps.

In the process of initiating the Drug Information Center, the Calgary Drug Advisory Society quickly came to realize that they were dealing with a larger phenomena than drug abuse. The Center proceeded to concentrate its initial efforts in problems related to drug usage. At the same time, it remained open to deal with a much wider area of problems than those specifically related to drug usage.

II. ORIGINAL OBJECTIVES

A) The Reduction of Public Fear Concerning Drug Usage

In order to deal with the problems related to drug usage, the Society saw it necessary to reduce the growing hysteria in order that a rational approach could be taken to drug related problems. The best tactic to accomplish this goal was the dissemination of information in relationship to drug usage. It was necessary first to gather the information to be disseminated.

(1) Information Collection

Budget considerations have limited the extent to which the Center has approached information collection. Despite this, the Center has developed a more than adequate library in the opinion of experts in the area of drug treatment. This has been largely made possible because other organizations in North America have taken on the task of

screening all relevant publications and providing copies and critiques of drug related articles for distribution to other interested organizations. The Center has taken advantage of these services.

For the last several years, A.A.D.A.C. has been collecting data of drug usage along with recruiting staff who are well versed in this area. It appears that both the Center and A.A.D.A.C. now have access to sufficient information to provide this service.

(ii) Information Dissemination

The methods of disseminating information can be basically divided into two categories: a) by having people come to the source of the information, or b) by taking the information to the people.

The Center uses both methods through its telephone and drop in information service and its speakers program. Aside from the quality of the information which has already been discussed, the only other factor involved is the acceptability of the information by its audience. The acceptability of the information by those people who contact the Center for information was not questioned as it was assumed that they would not have contacted the Center unless they were prepared to place some credibility on the information they received. The important criteria, therefore, in evaluating this service was the accessibility of the information, the degree to which its accessibility was known to the general public and the extent to which it was sought after. The same assumption was not true of the speakers program and therefore opinions of the recipients was also sought.

Through the volunteer training program, ongoing co-ordination of the volunteers activities, the back up resource people and the twenty-four hour service,*it was determined that fairly accurate up-to-date information is easily accessible to those people who contact the

*See figure 7 page 34.

The telephone survey *which was conducted amongst the population at large showed that 78.5% of the population were aware of the existence of the Center and 49% had sufficient knowledge of the Center to express an opinion as to its reliability. Of those people 98% held a positive opinion of the Center. This response was not homogeneous amongst divergent demographic groups. People under forty years of age made up a much greater percentage of those who knew of the Center and showed confidence in it. Likewise, students and professionals had a greater knowledge and greater confidence than other vocational groups. (*for complete results of the telephone survey, see Appendix E).

At present, the demand for information from the Center is not quite as great as it was in the early years of the Center's operation. (See Fig. 2 Appendix D). The trend over the past two years, however, has been relatively constant, allowing for seasonal adjustments, at about 150 requests per month.

The extent of the operation of the speakers program has been described on Page 26. This is a fairly extensive program aimed at a wide portion of the population. In order to assess the acceptability of the information disseminated in this manner, a random selection was made of spokespersons from ten groups who had listened to the presentation of the Center. They were asked their opinion of the accuracy and completeness of the information which had been presented. They all responded positively. Only one person raised any negative response, which was a concern that the speaker should have spoken more against the use of soft drugs, particularly cannabis.

Several people contacted through the random telephone survey had gained their knowledge of the Center as a direct result of the speakers program. They all responded positively to the Center as a result of those speaking engagements.

In the education area the Center, A.A.D.A.C. and the Calgary School Board all have been involved in recent years, in speakers programs in the high schools. There is some suggestion that the Center's program is accepted as more credible by the student audience, however, there is conflicting opinions in this area. It is difficult to assess this conflict as the goal of speakers presentations have varied from education about the most negative aspects of drug usage, where speakers focused on hard drugs, to an attempt to convey the message that all drug use has some negative aspects (ie. psychological dependency). This is, however, an area where overlap likely exists between different programs. Even if no overlap exists, the need for a greater degree of co-ordination between the three agencies exists, if services are to be efficient.

(iii) Effects of Information Dissemination

There definitely has been a reduction of the panic reaction which existed towards drug related problems five years ago. This reduction is not only true in Calgary, but across North America. There are a number of factors which have affected this reduction of public fear towards drug usage, not the least of which is related to the fact that drug usage amongst youth appears to be on a downward trend. As one of these factors, it is reasonable to conclude that the dissemination of information played and continues to play an important role. In this area it is impossible to deny the importance of the role played by the Drug Information Center.

B) Uniting of Efforts To Deal With Problems
Related To Drug Usage

As previously mentioned, problems relating to drug usage are a small part of a larger social problem relating to the development of the counter-culture. To unite all of the efforts in this area is an impossible task because not only is there not agreement as to what would be a desirable solution, but there is not even agreement on what the problem is. In spite of this, some progress in specific areas of drug related problems has been made.

These areas include the development of public support for rehabilitative programs for drug abusers, the co-ordination of some agencies who are working in the area of drug related crises and counselling and some co-ordination between law enforcement agencies and crisis intervention programs.

(i) Change in Public Attitude

In the mid sixties, drug usage was seen by the public only as a criminal activity which should be dealt with by law enforcement agencies. As drug usage increased, it was difficult to develop programs to deal with drug related problems in an atmosphere in which the drug user was on the opposite side of the law from the rest of society. The aforementioned information dissemination did much to alleviate this problem so that now many such programs are operated on public funds.

(ii) Program Co-ordination

With the development of a large number of programs of divergent agencies dealing with both different and similar aspects of drug related problems, the need for a co-ordination of these programs was evident. There are several major problems in this type of co-ordination, including problems stemming from the various underlying philosophies as to how a social problem should be dealt with. In Calgary, there is a specific problem of this nature. Based on what appears to be a false sense of civic pride, provincial government programs are often seen as Edmonton exerting itself on Calgary. As a result, there is a general resistance to provincial programs by civic officials and local social agencies. This problem is accentuated whenever a provincial government agency becomes involved in a controversy in some other part of the province which might have implications in Calgary. It is further accentuated when a local agency comes into conflict with a provincial government agency. As a result of all of these factors, there is less co-ordination in general between local agencies and provincial government agencies and specifically there is less than desirable co-ordination between the Center, A.A.D.A.C., the crisis unit of the Department,

and other agencies which are located in Calgary and providing relevant services including, the Juvenile and Family Court Services of the Attorney General's Department and the Department of Youth Culture and Education.

On the other hand, the Center works closely with the Calgary Federation of Family Services which has seconded a social worker to work with the Center, the A.I.D. Center, the emergency wards and social service programs of the Holy Cross and Foothills Hospitals, the City of Calgary Preventive Social Services department and the many other local agencies involved in programs for youth, drug users, and people experiencing crises. The only local agency * in those areas which is not closely co-ordinated with the Center is the Salvation Army's Suicide Division. (*For a list of Social Agencies interviewed, see Appendix F).

(iii) Drug Programs and Law Enforcement

As discussed earlier, there is a natural division between non-medical drug users and law enforcement agencies which creates problems for people mounting drug usage related programs. The Center, however, has developed a relationship with the City Police which ensures that treatment for crisis problems stemming from drug usage takes precedent over the legal problems resulting from the same drug usage. The relationship has also allowed the Center to have "street drugs" analyzed for toxic impurities so that a course of treatment or prevention can take place without fear of having staff charged with possession of the drug during the analysis.

C) Improve User-Parent Communications

The extent of this problem is easily measured by the fact that only 1.5% of the people contacted in the random telephone survey would turn to their family for assistance if they encountered crisis types of problems stemming from drug usage. In part, the Center has aimed its information program at lessening the division between parents and youth based on drug usage by the latter. The counselling program is also

aimed at reducing this communication gap by involving parents in their counselling program. Figure 13, Page 42 shows the significantly greater involvement of parents in the information and counselling services than in the crisis intervention and other services. While this is obviously a step in the right direction, there appears to still be a major task in closing this communications gap.

D) Provide Emergency Services

Aside from providing emergency information relating to drug usage on a twenty-four hour basis, the Center provides active intervention in any crisis situation. Where the basis of the crisis is drug usage (ie. overdose, bad trip, etc.) the Center's goals are to ease the anxiety which is being experienced as a result of intoxication, make available the necessary medical resources, bring about detoxification and provide short term counselling. The extent of this program is shown in Appendix D, Figure 3.

(i) Quality of Service

The effects of this program have been evaluated in three ways: a) The opinions of the clients have been solicited, b) the opinions of the staff have been solicited and compared to the opinions of the clients, and c) the opinions of other agencies have been obtained. Because of the divergence of opinion as to what constitutes effective crisis intervention treatment, original plans had been to place heavy emphasis on the clients' subjective evaluation of the treatment which they received. In order, however, to ensure anonymity of the client and reduce the bureaucratic image of more traditional services, the Center does not record clients names unless follow-up is necessary. Even in the latter cases, follow-up is usually short term and then records are destroyed. It was therefore not possible to gather a large enough list of clients from which a sample could be drawn. The problem was further compounded by many clients not being prepared to talk openly, particularly when drug usage was involved. As a result, the size of the sample was less than desirable and the method of selection would not meet usual

standards of scientific rigor. The sample therefore was used more to determine the extent to which the staff and volunteers of the Center could objectively assess their own performance. Much greater emphasis was placed on the opinions of other agencies.

On the client contact cards (Appendix C), the volunteer is asked to determine whether the client's situation had improved, not changed or become worse after receiving the Center's services. The evaluators later interviewed the client in an open-ended interview in an attempt to obtain answers to the questions shown in Appendix A. From those answers, the evaluators then completed the client contact cards and they were compared with those cards completed by the volunteers. (For detailed results of this process, see Appendix(I)).

While this sample is too small for statistically valid conclusions to be drawn, the 80% success ratio reported by the clients themselves and the 90% success ratio found by the interviewers compares favourably with the success ratio recorded in the records of the Center as taken directly from the volunteer contact cards. The success rate shown in the Center's records is depicted in Figure 16.

Of the two people who the interviewers felt showed no change in their condition one was suffering from loneliness and while the interviewers found no improvement, they felt that the congenial company of the Center staff had been very helpful. The other client was too psychotic to determine whether or not he had been helped, however, the staff and volunteers of the Center are still working with this person.

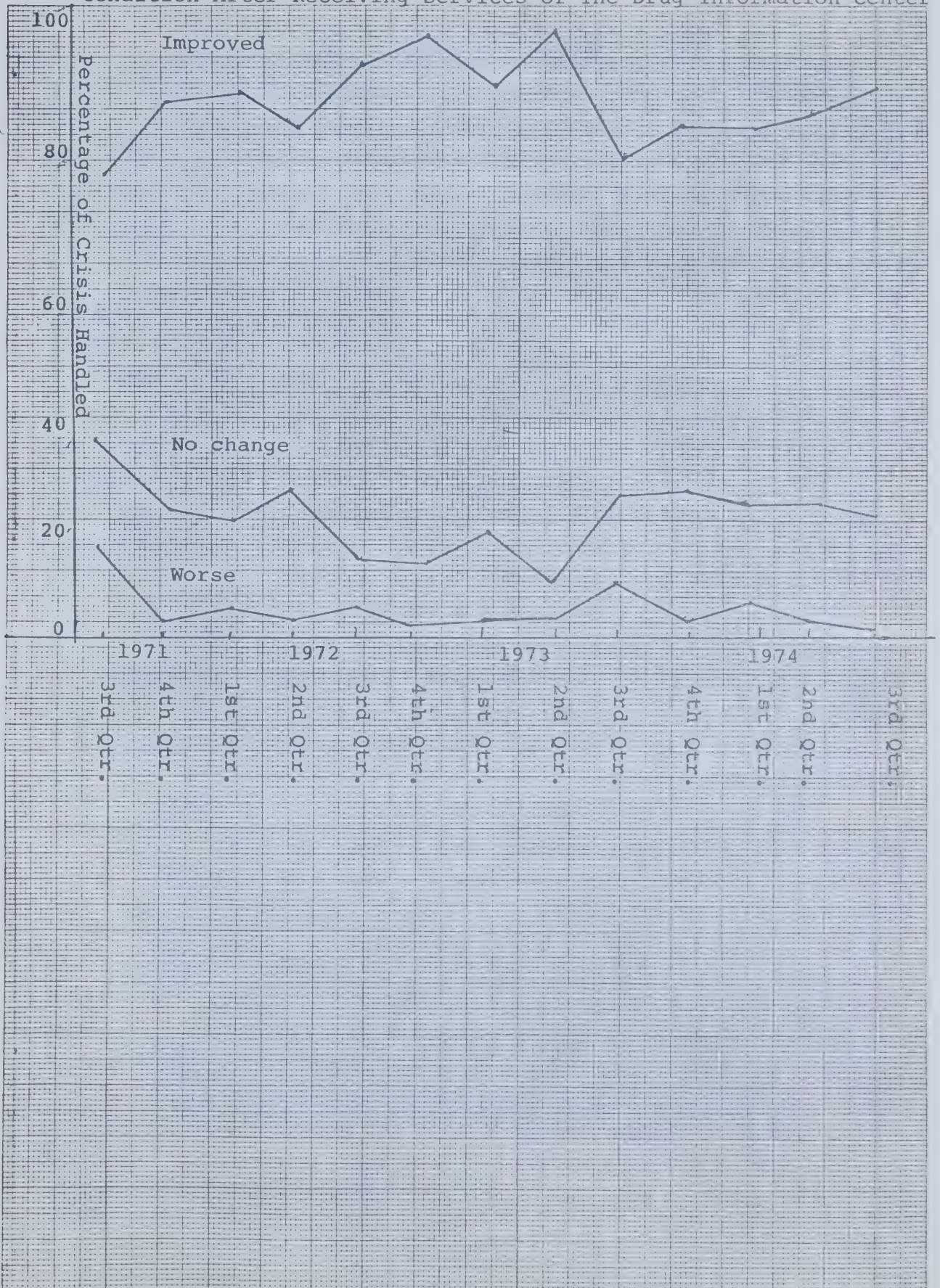
The sample represented a much higher proportion of drug related problems than is suggested in the records for the overall client population. Eight of the ten clients interviewed had problems related to drug usage (2 heroin addicts, 1 alcoholic, 2 heavy users of alcohol and tranquilizers, 1 heavy user of tranquilizers and stimulants and 1 heavy user of alcohol, cannibus and LSD). This is largely a

function of the process used in selecting the sample, as all of them were current users of the Center who had been using the facility for a sufficient period of time to be comfortable with the idea of being interviewed about their problem.

It is further worth noting the wide diversity of sources which referred the clients to the Center. This includes parents, friends, other relatives, hospitals, social agencies and police. This diversity in itself suggests a fairly wide scale confidence in the Center's ability to deal with problems.

In all, the interviews suggest that the Center's staff are relatively capable of self-evaluation and therefore some credibility can be given to the results in Figure 16. The small sample, and the other problems related to client assessment suggest the desirability of ongoing independent assessment of clients' reactions to the Center's programs.

Figure 16 - Subject Evaluation By Volunteers of Clients
Condition After Receiving Services of The Drug Information Center



The Center uses local medical facilities for referral where a medical problem exists as part of the crisis. In the event of problems such as toxic overdoses, then the client is taken directly to hospital. Discussion was held with the hospitals to determine the effectiveness of this service. Personnel at both hospitals contacted felt that the Center was making appropriate referrals to them for treatment. They spoke highly of the Center's service placing emphasis on its preventive nature of referring people for treatment early so that the amount of treatment required was minimized. Personnel at both hospitals felt that the Center played an important role in aiding young people to obtain medical assistance when they might not otherwise do so because of a distrust of traditional medical resources. They also felt that by handling many problems that did not require medical intervention, they reduced the pressure on the emergency and out-patient facilities of the hospitals so that the hospitals could devote more resources to handling medical problems.

The Center also refers clients to local agencies which handle specialized areas of problems such as the H.E.L.P. Society, the Self Help Society, the Women Emergency Shelter, etc. Personnel of these agencies spoke highly of the Center's activities based on their contact with clients referred by the Center.

In a small percentage of cases, it appears that the Center has not been helpful, but in fact, probably detrimental to the client's wellbeing. This not only was revealed in discussions with other agency personnel, but is recorded in the records of the Center which are shown in Figure 16. Where it was possible to identify these instances, they were examined in an attempt to find the reason why the Center was effective in most cases but had a negative effect in these few situations. One type of problem was isolated which does not appear to be handled very well by the Center.

While the Center's social worker is quite eclectic in his approach to counselling, the overall approach of the Center to treatment appears to be characterized by a client-centered attitude in which the client is encouraged to make choices regarding his life, not based on earlier socialization patterns, or what Freud would call super-ego demands, but on a rational interaction with his environment. This is a very common approach to psychotherapy. The client is encouraged to liberate himself from his past socialization and make present decisions based on a concrete analysis of his surrounding environment. For example, the drug abuser is encouraged to discontinue drug abusing behaviour not because he is told to by an authority figure, but because he recognizes the negative effects on himself and based on that realization, decides himself to stop. This approach is very complimentary to the life style of the counter-culture which rejects authority figures as a determinant to behaviour.

There are, however, a small portion of the younger population who are seeking external direction to their lives and deliberately abuse drugs as a method of demanding that type of direction from others. This type of client is usually not helped, and often harmed by the client-centered approach. The volunteer staff of the Center do not seem to have been trained to a point where they can readily identify this type of problem and refer the client to an appropriate source of assistance.

This problem was widely discussed with a number of agencies who have expertise in the area. All of them recognized the problem and agreed that it would likely occur in any situation where paraprofessionals served the intake function for the agencies clientele. They all agreed, however, if the Center did not use paraprofessionals, it would lose its "street-image" and with that they would lose a major portion of the clientele for whom they did provide a useful service. The problem was discussed with the Center's staff and they agreed that further volunteer training in this area would be beneficial.

(ii) Trend of Crisis Services

Figure 3 of Appendix D depicts the trend of client demands for crisis services. These demands have decreased from the level of several years ago. Figure 8 on Page 36 shows a large decrease in drug related problems involving L.S.D. and other hallucinogens during the same period. Figure 9 on Page 38 shows that a large percentage of problems involving these drugs are crisis problems. It is, therefore, easily concluded that the decrease in demand for crisis intervention services is directly related to a decrease in the number of crises involving these two drugs. In the opinion of both the Center's staff and other people in the field, this phenomena has two causes: a) There is a trend by unsophisticated young people away from experimenting with hallucinogens and, b) the dissemination of information to the general public about how to respond to a person having a "bad trip" has reduced the need for a crisis intervention service in this area.

In all other areas of crisis problems, both involving drugs or otherwise, the trend has remained relatively steady over the years.

E. Long Term Preventive Programs

Through its attempts to achieve the other goals of the Calgary Drug Advisory Board, the Center has in fact been moving towards the achievement of this goal. The main strategy for long term prevention of drug usage related problems has been centered on education of both the potential user and the community at large and at reducing the communication gap between youth and parents.

The Society, however, has not attempted to deal with the myriad of social and economic phenomena which underly the development of the counter-culture and the resulting drug usage. They have recognized that this problem is beyond the scope and ability of a local social agency.

III OBJECTIVE AND PROGRAM CHANGE

The gradually evolving changes which have taken place in the objectives of the Society are more a change of priorities rather than a discarding of early objectives in place of new ones. All of the early objectives still exist, however as the information vacuum about non-medical drugs was partially filled by the Center and as other agencies moved into this area, the Center placed less emphasis on this program. Likewise, as less problems came forward demanding crisis intervention for people intoxicated on hallucinogens, the Center placed less emphasis on that service.

In a similar manner, the Center has had more and more demands for non-drug related crisis intervention and counselling programs and therefore has expanded its activities more in these areas.

IV PLANS FOR THE FUTURE

The Center is now at a point where drug related problems still exist and make a sufficient demand on the Center that the present scope of operation is required. At the same time, however, these demands are not sufficient to fully utilize the Center's resources. In other words, there still appears to be a need for a twenty-four hour service (See Figure 7, page 34) but the personnel spend a considerable portion of each shift sitting waiting for a client to phone or drop-in.

There also appears to be a large void in easily accessible general crisis intervention services as indicated by the fact that 32% of the people contacted in the telephone survey indicated that they would not know where to go if faced with an emotional problem of crisis proportions.

Based on these two situations, the Center plans to move into the area of general crisis intervention and accompanying short term counselling. They plan to accomplish this change by creating a parallel image of the Center which is not so readily connected to drug users and the counter-culture. This new image will be created by advertising under the name "The Center" in places that are more accessible

to the established society. They also plan to recruit a greater number of older volunteers who have a more conventional life style. At the same time, they will continue to operate under the name "The Drug Information Center" to maintain their present clientele. This change is expected to not only increase their degree of non-drug related activities, but also increase their activities with socio-economic groupings outside the young, counter-culture community.

Other local agencies have expressed some concern about these plans, conceding that it would probably be advantageous for the Center to expand into more non-drug related areas, but continuing to aim their appeal at the socio-economic grouping where they are presently enjoying such success. It is possible that some of the concern of other agencies is based more on a desire to protect their own territory of clientele, the older, more established portion of the community, however, there is definitely a real concern that in attempting to widen its appeal, the Center would lose enough of its present image that it would be unable to attract its present clientele. As there is no other agency in the community serving this population with any degree of success, a void would definitely be created if the Center lost its appeal to that segment of the community.

V THE HOUSE

"The House" has operated continuously since June 1973. Initially the House operated as a treatment facility for highschool drop-outs who were having difficulty making the transformation to adult society. The capacity of the House was eight clients and the average stay was 3 to 4 months.

As the House has become more of a halfway house for teenagers with long histories of institutionalization, the average stay has increased to slightly over seven months. Clients range in age from 14 - 19.

The therapeutic approach of the House is to use group therapy in an attempt to have the client set his own behavioural parameters based on peer group reinforcement.

With respect to the present client population, the success of the House can be gauged by two criteria. The ability of the client to integrate into society as a result of treatment and the number of clients who require re-institutionalization. While detailed records are not available, the latter group would appear to be very small. Of the former group, there are mixed reactions from the clients as to their ability to reintegrate, but it appears that they are able to do so with a minimum use of public support systems.

The Calgary Drug Advisory Society is presently making plans to have the House set up as a separate legal entity. This is desirable from the point of view of the staff of the House. At present, the Society only serves a management role in respect to finances and because of the intensity of the treatment process, it is difficult for the Society to play a larger role. Because of the very specialized type of problems dealt with by the House and the longer more intense treatment process in comparison to the short term widely varied type of problems dealt with by the Center, there is potential conflict with respect to treatment between the two projects and therefore, a formal separation would be desirable.

The activities of the House have been largely directed by the activities of the social worker who is in charge of the treatment program. The one serious concern that was raised about the program of the House was its possible over-dependence on this one person. This problem should be seriously considered in developing the new legal structure which would be created if the Calgary Drug Society proceeds with its plans to separate the House from its present structure.

VI GOVERNMENT OBJECTIVES AND APPROACH

The objectives of the government in funding the Drug Information Center are not entirely clear. In 1970, the Drug Advisory Council which was involved in the formation of the Center, seemed to see the role of the Center as primarily related to A.A.D.A.C. and not to the preventive Social Service provisions of the then Department Preventive Social Services. In other words, the problem was seen primarily as a drug abuse problem, rather than drug abuse being symptomatic of deeper social problems.

A.A.D.A.C. had been recently established and had a broad mandate in the area of drug and alcohol prevention and treatment. Its role at that time was perceived primarily as one of encouraging the voluntary and private sector to develop services and programs through the provision of financial resources, research assistance, and co-ordinating efforts of various local groups. Based on that concept of the A.A.D.A.C. role, the province began to provide funding to the Center as well as a number of other agencies. The initial grant of \$10,000 came about as a result of a direct appeal by the Mayor of Calgary to the Minister of Health. A.A.D.A.C. was then asked to budget for the Center in subsequent years. Based on the understanding of the problem at the time, the A.A.D.A.C. mandate and approach, it seems there is general agreement that it was appropriate for A.A.D.A.C. to provide the funding.

In 1971, the Provincial Government in Alberta changed. There were also changes in commission membership and in the chief executive officer of A.A.D.A.C. Those changes brought about a change in philosophy and approach on the part of A.A.D.A.C. It began to see its role as one of more direct involvement in the provision of service programs. It changed its funding to a fee for service basis because of more emphasis on participating in cost sharing programs and it set treatment and rehabilitation as its priority and focused primarily on alcoholism problems with other drug programming and treatment to be integrated as part of the overall program.

While these changes in government philosophy and policy were taking place, the Center was also changing and so were the drug abuse problems. There were fewer crisis problems as the existing service systems learned how to deal with them and as young people themselves learned how to cope with withdrawal symptoms. There had also been a number of new, more long-term treatment programs developed to help alleviate the crisis problems of severe and chronic cases. The information services in other agencies also began to develop. These included services in the school system, the police services, and in A.A.D.A.C.

The Center gradually evolved a more general crisis counselling and intervention service. Its clientele were still similar in terms of characteristics, the drop-outs, the socially maladjusted and the socially alienated youth. The number of drug crisis gradually dropped to its present level of about 20% of total services provided. The Center continued to act as a contact place for the particular group it served and to provide a channel to help these people seek other appropriate services where problems were severe and of long standing, or to provide support to those clientele needing short term help with a crisis problem. The role of the Center modified to become a general information service along with a referral service and a crisis counselling service.

As these changes took place, it appears A.A.D.A.C. in particular and government personnel both local and provincial, began to change their views as to where funding should come from and as to what government agency the Center should relate to. The objectives of Preventive Social Services focus on the prevention of social problems and the provision of social service programs both of a treatment and rehabilitation nature. Funding is generally channelled through the Municipal Government with the Municipality bearing some 20% of the cost. The local government is left to determine goals, priorities and appropriate services within

the frame of reference of the enabling legislation. Based on this mandate of Preventive Social Services, there is now a general consensus that funding should be provided from that source and be channelled through the City of Calgary. There was some opinion expressed that it might still be appropriate for A.A.D.A.C. to fund that portion of the Center's services related to A.A.D.A.C.'s area of responsibility, ie. drug abuse and drug related problems.

There were differing views on what the Center's role should be or for that matter was at the present time. Those most closely related to the social service field and to government administration in Calgary, agreed that the need for the Center existed. Even if its role was changing, it continued to serve a population group with serious social problems not being reached by any other agency. Government officials in Edmonton, far removed from the local scene, seemed to view the Center as a drop-in Center for alienated youth and the street crowd. They conceded it had some contact with those youth using drugs, but saw its services as either unnecessary or valuable and worthwhile but of low priority when compared to other pressing community problems and needs.

There was a view expressed by several of those who participated in the initial development of the Center, that it hadn't fulfilled its mandate, since it had moved in the direction of a service agency with its own paid staff. The original concept was to use seconded staff and volunteers and to help co-ordinate the efforts of the existing system as well as to promote drug education and information services. These participants viewed its present role as unnecessary or at least unrelated to the original objectives. They also were of the view that many of the existing agencies such as the police, the hospitals, A.A.D.A.C., the school system, etc. were now satisfactorily providing those services which did not exist in 1970.

Several of these participants appear to have had a considerable effect on the development of the position and attitudes taken by commission members toward the Center. This development was closely tied to A.A.D.A.C.'s perception of whether the Center was performing a needed service and the decision that what it was doing was not sufficiently related to A.A.D.A.C.'s objectives and priorities to warrant continued funding.

SECTION V EVALUATION FINDINGS ON THE IMPACT OF THE DRUG
INFORMATION CENTER ON OTHER RELATED FACTORS

I COMMUNITY SUPPORT AT OFFICIAL LEVELS FOR THE
CENTER

Support for the Center and the activities it has carried out in Calgary is very positive and strong at the local political level and at the level of a number of senior officials in local government departments and agencies. Officials interviewed included the Mayor, the Chief of Police, the Director of the City Welfare, Directors of several regional welfare offices of the Provincial Department, as well as two of the Calgary M.L.A.'s.

There were several officials both local and provincial who had reservations about the Center, its activities, and the continued need for the activities of the Center. In some instances, these persons acknowledged the need for the Center and the value of what it was doing, but questioned its relevance to the drug problem and questioned the priority of this service over other needed services in Calgary. Persons interviewed in this category included the Regional Director for A.A.D.A.C., the supervisor of Drug Education with the schools and the Executive Director and the Research Director of A.A.D.A.C. There were also questions raised about whether the Center was performing the function it said it was performing. It was also claimed that if it was, its activities overlapped with those of A.A.D.A.C. who was either providing or able to provide similar services.

There seems to be a basic difference of philosophy between these two groups of persons. The first group strongly favored the provision of such services by the local community and in particular by the voluntary sector of that community. In part, this difference represents a difference in political ideology. However, other reasons were also given in the support of both positions. The first group strongly supporting the Center listed the following among

reasons for that support:

- people with problems feel more comfortable going to an informal, unstructured agency than to a government agency.
- the Center has more credibility in the local community than A.A.D.A.C.
- frontline services should be provided by the community. The Provincial Government should assist with financial and professional support services.
- a voluntary agency can tap a great deal of local talent, initiative, and interest by use of volunteers. This is difficult for a government agency.
- the Center has established credibility with many persons in the professions and in the community service system which makes for utilization of Center services by these groups for their clientele. Many of these same groups do not have a similar working relationship with A.A.D.A.C.
- Volunteer organizations have roots in the community and will be more attuned to community sensitivities. They are less likely to abuse their power.
- the Center has helped increase understanding of problems among police and other community officials who viewed the drug problem from a negative perspective.
- service is available when needed not at the convenience of bureaucrats.
- service provided by the Center is not being provided elsewhere.
- the Center provides alternative ways of dealing with the problems of a segment of society who has not been too comfortable in seeking services in the past.
- The Center provides the confidentiality and anonymity drug users need to be certain of, before they will seek services.

- Volunteers can provide the services as well as, or better than professionals.

The second groups supported its views with arguments such as the following:

- duplication of service - A.A.D.A.C. is, or can provide the service.
- the Center is not performing the function it set out to perform.
- It is developing a new agency with paid staff. This is not in keeping with the original concept of co-ordination and assisting the community and its service system to better deal with the problems through existing structures.
- their staff and volunteers are not qualified to deal with the problems and needs of the clientele they serve.
- It is no longer serving a significant group with drug problems.
- services of this type in other Canadian Centers have ceased operations because they were not needed.
- the service provided is low priority when compared to the need for treatment and rehabilitation of alcoholics in particular.
- the Center is not and refuses to be accountable.
- they use questionable methods in obtaining support.
- the education and information services have disturbed many community groups and people.
- they are only providing limited services. Their statistics are not accurate since they interpret as service, contacts which have no service content.

II RELATIONSHIP OF CENTER SERVICES TO PREVENTIVE SOCIAL SERVICE

One of the basic questions which arose during the process of the discussion related to whether funding should come from A.A.D.A.C. or through Preventive Social Services. It should be noted that regardless through which channel the funding is made available, the Province could in theory qualify for cost sharing from the Federal Government under the

Canada Assistance Plan. This doesn't mean that such cost sharing is automatically available, since the services so funded must meet certain basic criteria spelled out in legislation and in regulations. In order to qualify for cost sharing, it is not necessary for money to be made available on a fee for service basis.

From a Provincial point of view, therefore, the funding question hinges on the nature of the services provided by the Center and the respective mandates given to A.A.D.A.C. and to Preventive Social Services. In discussion with the above persons, it was generally agreed that at the time plans were being developed for the Center, the main concern was to deal with the drug problem. The symptoms being dealt with were seen basically as falling in the health area. Therefore, the Provincial Health Department and A.A.D.A.C. were the most logical way for the Province to participate in program development and in funding of the Center.

There was also almost unanimous agreement by all of the respondents that the problems and needs had changed to some extent. In addition, as the community came to better understand the nature of the drug problem, it became clear that drugs themselves were not the major problem. Drug use was a symptom of social dislocation, social disorientation and personal problems being experienced by the users. Also, over a period of time, fewer people came seeking help with drug crises but more came seeking help with other kinds of crises and other kinds of personal problems. This has led most of the above participants to conclude that the current and future role of the Center should be in the broad area of youth problems and the problems of the alienated. This has also led most persons interviewed to the conclusion that the Preventive Social Services program of the Province would be the more appropriate way to provide program and funding support to the Center than to provide such support through A.A.D.A.C.

Several persons expressed the view that A.A.D.A.C. should continue to be involved to the extent that the Center still dealt with drug related problems, ie. funding should come from several Provincial Government sources or from A.A.D.A.C. and the City with the portions dependent on the portion of service provided by the Center to those with drug or drug related problems.

III VOLUNTEER TRAINING PROGRAM

Since it commenced operations, the Center has operated an extensive training program for volunteers. During that time, approximately 450 people have received volunteer training from the Center.

The training program is comprised of several sessions in pharmacology, alcoholism, first aid, counselling and the policy and procedures of the Center. These are carried out in a combination workshop - lecture style. These sessions are integrated with several closely supervised work sessions. A typical training session agenda is outlined in Appendix G. After the initial training period, the volunteers are assessed by the Center's staff and encouraged to conduct a self-evaluation both of themselves and the training program. After the initial training period, there is some follow-up through volunteer meetings.

Often volunteer meetings result from the impetus of the volunteers rather than the Center staff. As a result, many meetings result from the volunteers' desire to examine policies and procedures and therefore, these sessions become more business meetings than follow-up training sessions.

This approach appears to be quite useful in involving the volunteers in an ongoing examination of the policies and procedures of the Center. Several other social agencies describe the Center's volunteer program as the most successful in Calgary in terms of getting young people involved and in maintaining their involvement. Many volunteers attributed this success to the fact that not only did they provide the volunteer services, but they felt a more overall involvement

in, and therefore commitment to, the overall operation and direction of the Center.

Two major side benefits of the volunteer program are: a) the program has involved large numbers of people from the general community in the solution of drug related problems and, b) the program has prepared a large number of people to deal with crisis situations.

When random telephone interviews were conducted, a considerable number of people who had knowledge of and spoke favourably about the Center, had come to their knowledge through a friend or relative who had worked at the Center. Many people working in related social agencies have also served as volunteers of the Center, thereby facilitating co-ordination of the Center and related services at the practice level.

Twenty-five ex-volunteers of the Center were randomly selected and interviewed using the questionnaire shown as Appendix H. It was originally planned that a workshop be conducted amongst these people, however, time restraints of this study made that procedure impossible to arrange. Ex-volunteers were therefore interviewed individually. There was no relationship between degrees of training and attitudes towards the training program. All volunteers interviewed had received training and all thought that it had been useful. Nineteen people indicated that the training had been sufficiently complete. Two people thought that more training in counselling and crisis intervention techniques would have been useful, however, after serving for a while as a volunteer, both felt confident to handle most situations which arose. Six people indicated that more follow-up training after the initial training period would have been useful.

IV STUDENT PLACEMENT PROGRAM

Several people who had taken practicum work from the Center as part of a related course of studies were interviewed. University personnel were also interviewed. All of them agreed

that the practicum experience had been useful, however, they also felt that if practicums were to receive academic accreditation, a more organized intensive training experience would be necessary.

V OTHER SOCIAL AGENCIES

The Center interacts with a number of different agencies in a number of different ways depending both on the services of the other agencies, and the relationship between those agencies and the Center. In most cases, however, the relationship appears to be more a function of the services provided or the population served. These other agencies can be categorized as follows:

A) Other Crisis Intervention Services Directly Related To Drug Usage.

(i) Bug Desk. This is a drug crisis intervention service provided by students of the University of Calgary. It has been operating on and off since 1970 but has been relatively inactive for the past year. When it is operating, it provides services from 7:00 p.m. to 11:00 p.m. The remainder of the time, the phone is answered by a recording referring the caller to the Center.

(ii) Renfrew Recovery Center -(A.A.D.A.C.)

This is an alcohol and drug crisis intervention, detoxification and withdrawal treatment program. It has been operating since October 1974. 85% of the cases it deals with are alcohol related. Most agencies in town, including the Center, view it as the best place to refer people with alcohol problems, particularly if they are encountering problems due to intoxication. It also handles a number of heroin withdrawal cases. It has a capacity for 30 patients. The average patient stay is 4.75 days. It treats many more cases, however, where only a detoxification service is provided and the patient does not take further treatment.

With the drug crisis intervention service, there is a potential overlap of activities between the two centers, however, the population served by the two services do not appear to overlap. While the Renfrew Recovery Center has dealt with clients varying in age from age 14 to age 70, the average age is 41.3 years with a standard deviation of about 10 years. Statistically (PL.001) this is a completely different age group than the age group served by the Center.

Difference over some approaches to treatment used by A.A.D.A.C. and the dispute over A.A.D.A.C.'s decision not to fund the Center have resulted in some strain in the relationship between these two facilities.

B) Other Crisis Intervention Services

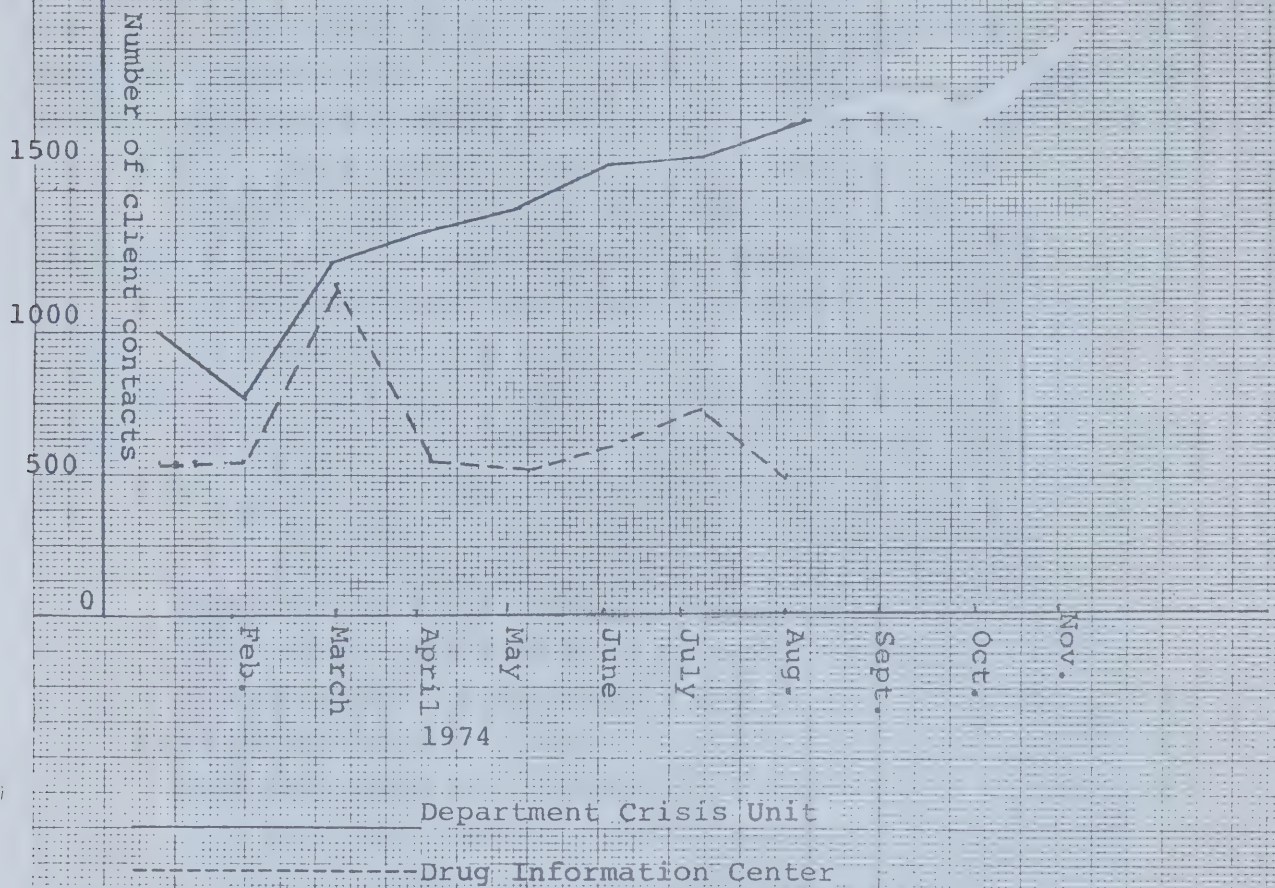
(i) Canadian Mental Health Association (CMHA)

For a short period of time, CMHA sponsored a general "Street-level" crisis intervention service. This service was only operated for four months and has since been discontinued. Statistical information regarding the scope of this operation is not available, however, while it was operating, the Drug Information Center's client contacts fell to the lowest point since its commencement. When the CMHA service discontinued, the Center's client contact level again rose to normal levels suggesting that there was a very definite overlap both in service provided and the population served.

(ii) Department of Health & Social Development Crisis Unit -

In February 1974, the Department opened a crisis intervention center to handle those problems which by statute are the Department's responsibility (ie. child apprehension, indigent burials, emergency welfare). The Crisis Unit operates in close conjunction with the A.I.D. Society, sharing premises and answering their phone-ins at night. The Unit staff try to deal with all types of problems that come their way and as a result, the scope of their activities is considerably broader than originally foreseen. Figure 17 depicts the total client contact in relationship to the Center.

Figure 17 - Relationship Between the Scope of Activities of the Department Crisis Unit and The Drug Information Center



A comparison between the different activities would be more revealing, however, both operations use different categories of problems and therefore comparison is difficult.

The extent of activities of the Department's Crisis Unit does not appear to be a determinant to the scope of the Center's activity. It is therefore assumed that the Crisis Unit is either serving a different population or dealing with a different type of problem.

(iii) Salvation Army Suicide Line - The Salvation Army maintains a twenty-four hour crisis line. This operation serves a small specific portion of the population which does not seem to overlap at all with the population served by the Center. There is very little co-ordination between these two operations.

(iv) Hospitals - All of the hospitals in Calgary have an emergency department. While there is some contact between the Center and all of the hospitals, there is a much closer relationship between the Center and the Holy Cross & Foothill Hospitals. In both cases, this appears to be a very good relationship, with personnel from both hospitals stressing the desirability of the Center continuing to operate with the population they are presently serving. The relationship between these hospitals and the Center has been further described in the previous section.

C) Counselling Service

(i) Federation of Family Services - This is a federation of a number of family counselling services, including the Calgary Family Service Bureau, the Catholic Family Service and the Pastoral Institute. Through the federation, the Calgary Family Service Bureau seconds a social worker to the Center. This helps to maintain a very close liaison between these services and ensures appropriate referrals. All of these agencies felt that the Center played an important role with the population which it serves. Some concern was expressed about the potential of the Center losing its present image, and therefore its present attraction, if it tried to diversify its client population too drastically.

(ii) University of Calgary - Counselling Center.

This general counselling program serves a very limited population, mainly confined to the University community. It has worked closely with the Bug Desk but has little direct contact with the Center.

D) Information Services

(i) A.A.D.A.C. - The commission operates a drug information service. There was a considerable overlap between this program and that of the Center as A.A.D.A.C. was developing its program. This overlap seems to have declined in the past two years as the Center has placed less priority on this service in areas where it is being provided by the commission. The differences between A.A.D.A.C. and the Center over funding has left relations somewhat strained, which possibly detracts from an optimum of co-ordination between these two programs.

(ii) Calgary Board of Education - The Board of Education operates a drug information program in the schools. These activities seem to overlap to some extent with both A.A.D.A.C. and the Center. There were, however, indications that none of these services is totally capable of being accepted as a credible source by all of the school systems population. A much more detailed comparative study of the effectiveness of these three programs in this area would be needed before any meaningful conclusions could be drawn.

(iii) Canadian Mental Health Association - The Association operated a drug information service until two years ago. At that time, their information officer left to become director of the Center. Since then, CMHA have been working on the assumption that the Center will handle all of the required drug education work and the Association has therefore withdrawn from that area.

(iv) The Advice, Information & Direction (A.I.D.)

Center - Operates as a general information center with possibly the best access to information in Calgary. A.I.D. operates in close conjunction with the Center with both agencies making a large number of appropriate referrals back and forth. A.I.D. personnel feel that they attract an older population than does the Center and therefore, feels that it is important that both operations continue in this area with close interagency co-ordination. This co-ordination appears to exist.

VI STAFFING OF THE CENTER

The Center has deliberately attempted to recruit a fairly diversified staff in the areas of education and experience. In general, they have been successful at doing this. By operating on a democratic consensus decision-making model, this diversity has added to, rather than detracted from, the quality of service provided. All of the staff appear to be qualified and competent at the duties to which they are assigned.

VII ORGANIZATIONAL STRUCTURE

By operating under a lay community board, the Center has optimized the potential for community input and direction to their activities by people who are concerned about the problems which the Center is designed to deal with. The fact that the board, which is the Calgary Drug Advisory Council, has close ties with a number of other services providing assistance to drug users and to persons experiencing a variety of other crisis problems, appears to aid in the co-ordination of activities, the maintenance of communications between the Center and these services in general could be said to promote good working relationships.

VIII FUNDING ARRANGEMENTS

Due to the short term nature of funding arrangements which have been made with the Center, a considerable portion of staff time, particularly that of the Director , is spent on ensuring continued funding. This, of course, is dramatically increased when the danger of funding being discontinued becomes evident. Uncertainty of funding due to government priorities has also resulted in some competition for funding from various agencies, thus detracting from optimum co-ordination between different agencies' programs. To some extent, the changing priorities of government funding has the potential of encouraging community agencies to alter their objectives and priorities to optimize their potential for continuing government assistance. Short term government funding, therefore, tends to detract from efficient, purposeful activities of community agencies which are dependent on government support. These inefficiencies increase or decrease as a direct function of the terms of the funding period.

IX COST BENEFIT RELATIONSHIP

For the 1975-76 fiscal year, the Center has requested a grant of \$60,000 or \$5000 per month. Trends of operations suggest that the extent of activities will be similar to the previous two years. While it is not possible to fully analyze the cost benefit relationships, from these assumptions some insights can be drawn.

Table 3 on Page 30 provides a breakdown of the percentage of total client contacts seeking each service, however, they do not reflect the amount of time devoted to each activity. For example, counselling and crisis services represent only 23.8% of the total client contacts, but represent a much greater amount of time than a simple information call.

It is also impossible to assign a time-service relationship to the large number of inactive hours necessary if a twenty-four hour service is to be maintained, however, Figure 7, Page 34 suggests the importance of a twenty-four hour service.

In the figures available, no consideration has been given to the time spent on the speakers program, however, this is a fairly extensive service with an average of 8.6 speaking engagements per month to an average audience of 24.3 people per engagement.

Detailed records are however available for numbers of hours spent on crisis intervention and counselling. These figures do not include the counselling done by the social worker as his wages are provided by the Calgary Family Service Bureau, and not from the Center's grant. On an average, the Center spends 144 hours per month on crisis intervention and 76 hours on counselling over and above the social workers activities. If these services were provided by professionals on a fee-for-service basis, they would cost \$2730 and \$2280 per month respectively.

When it is considered that these services could not be provided on a fee-for-service, twenty-four hour per day availability basis without the added cost of a twenty-four hour a day referral source, then these services seem to justify the total financial cost by themselves. There is no way of determining the cost relationship for a fee-for-service paraprofessional operation as no such service exists from which a cost figure can be derived. The only alternative would be to hire a paraprofessional staff, however, on a twenty-four hour-a-day basis, even with only one person on duty at a time, this would require a minimum staff of five persons plus costs of training, administration and overhead expenses. This compares to the present 5½ person staff (the social worker excluded) of the Center.

SECTION VI CONCLUSIONS

I ORIGINAL OBJECTIVES

Given the public concern in 1970 with respect to the rapid proliferation of non-medical drug usage by young people, the large numbers of young people requiring hospitalization as a result of drug usage, the serious information vacuum about the effects of drugs and the wide communication gap between generations, the original goals and objectives of the Calgary Drug Advisory Society were a reflection of a widely felt community need. Information was needed both by youth who were experimenting, sometimes unwittingly with very dangerous drugs and by parents who had very limited knowledge of the effects of different drugs and as a result, often expected the worst. The panic situation that was prevalent in Calgary only mirrored the phenomena prevalent in almost every city in North America. The two fold attack, both on the information void, and drug related crisis was both logical and suitable to the community needs.

To a large degree, the information void was filled and it would be remiss not to give the Drug Information Center a major share of the credit. In recent years however, other sources of information have developed to handle a major portion of the on-going community need in this area. The Center, however, continues to have a role to play in this area, particularly with the younger generation where the credibility of the Center definitely has the potential to complement other programs.

The extremes of drug abuse resulting in crisis situations has subsided, however, the problem has not been eliminated. As most non-medical drug usage is still illegal, the problem of people needing help but fearing prosecution or other social repercussions still exists. The Center has been the only facility where the drug-user has consistently been able to seek help in a time of trouble with a degree of confidence that he can remain anonymous. The fear of exposure

and possible prosecution has often resulted in unattended narcotics overdoses becoming fatalities and unattended "bad-trips" resulting in long term emotional damage. While there are other facilities, with greater degrees of expertise in dealing with these problems, many people will not use them when they are needed, unless an agency with the credibility and open image of the Center acts as the referral agent. So far, for large portions of the youth population, no such agency has developed with the exception of the Center.

Given the divergencies of opinions and the wide number of social, economic and political factors which converged on the "drug problem" of the early seventies, the Calgary Drug Advisory Board probably did as much as was possible to unite the community effort to deal with drug related problems. Since the problems related to drug usage are only representative of much greater cultural and social problems, total community homogeneity in approaching the problems is an impossibility. The almost total lack of community opposition to the Program of The Center (2%) revealed in the random telephone survey which was conducted as part of this study came as a suprise to the researchers. These results more than speak for the efforts of the Center to bring unity to bear on the civic approach to drug related problems.

II CHANGES IN OBJECTIVES & PROGRAM

The decision to handle a wider range of problems than those related specifically to drug usage not only resulted in a much greater acceptance and use of the Center's resources by its clientele, but also reflected the fact that drug abuse was not an isolated phenomenon, divorced from greater social problems.

The decision to expand into more and more non-drug related areas while continuing the drug related program was a good decision from other perspectives. Drug related problems coming to the attention of the Center decreased. As a result

the public pressure for programs to deal with drug problems has declined. Drug related problems have not, however, been eradicated. Because the Center has expanded into other areas of socially useful activities, it has been able to carry on the program related to drug problems in spite of the fact that public pressures have decreased but problems still exist.

By handling a wide variety of problems, the Center has created the image of a useful place to seek help in the minds of many young people. Often drug usage is not defined as a problem by young people, however, as a result of seeking the Center's assistance in other areas, problems related to drug usage can surface and be dealt with.

III FUTURE PLANS

The researchers totally concur with the wisdom behind the Center's plans to expand into a wider variety of problem areas. Some problem exists, however, if the Center attempts to serve all segments of the population. Some people, when faced with problems beyond their ability to cope, turn to traditionally recognized experts and place their faith in those agencies which portray the image of traditional expertise. Other people in the same situation distrust the traditionally recognized agents of assistance and seek to avoid them. It is doubtful if one agency can portray both images. While these two populations do not confine themselves to separate demographic categories, there is a correlation between both age and socio-economic status and which direction a person will turn when in need of help. The Center definitely has an image that will attract a large client population. Some of those clients will not be representative of the norms of the Center's client population. They will, however, seek out and benefit by the Center's services. Success with these people can easily lead to the conclusion that the Center can in fact fill the needs of all of the demographic groupings. Such a conclusion is not, however, supported by the data gathered in this study.

IV REALIZATION OF GOVERNMENT OBJECTIVES

Based on background material which suggests that the provincial government in 1969 and 1970 was concerned about the serious drug problem which was developing and was desirous of helping communities take action to deal with this problem, the evaluators must conclude that significant progress has been made by the Drug Advisory Council through the Center in achieving these objectives.

The Center not only has provided an effective crisis intervention service to persons experiencing crisis problems with drugs, it has assisted parents, the police, the social service system and the community generally to understand the drug problem, to be more tolerant to drug users, and to deal in more appropriate ways with the problem. The marked decrease in drug related services provided by the Center is substantiated by the view of officials in the police department, the Board of Education, the Mayor, and others, that the use of non-alcoholic drugs is much less of a problem now than it was five years ago. This is not to suggest that substantial quantities of drugs are not still used in Calgary. The general view was that people, as a result of being more knowledgeable, were reacting in more appropriate ways. There was a less punitive reaction on the part of the police, other agencies and the school system, and less panic on the part of parents. As a result, more effort was directed at helping users get early treatment and as well emergency health services were more responsive and therefore more likely to be used by both parents and young people.

The drug information and education program as well as the volunteer program have helped develop a pool of more knowledgeable community people and have also likely helped improve communication between parents and children, teachers and students, etc., leading to many problems being resolved without outside intervention.

It is also evident that the government agency which was most directly concerned with this problem in 1970 has changed both its approach to providing and supporting service and has altered its priorities. As a result, it sees services or agencies such as the Center only marginally related to its mandate and area of responsibility. Whether this is, or is not a correct orientation is a question of government policy and not directly the subject of this evaluation. What is important however, is the fact that this change has significant implications for the continued support base for the Center.

V OTHER FINDINGS

A) Volunteer Training Program

By carrying out a substantial volunteer training program, the beneficial effects have been three-fold.

(i) The training program created a large pool of paraprofessional workers which enabled the Center to carry out its program at a considerable cost-savings.

(ii) The number of lay volunteers created strong community support both because of the large number of people involved and because a considerable number of these people later became involved in related community services.

(iii) The large number of trained paraprofessionals resulted in a wide dissemination of information about drugs and ways of dealing with drug related problems.

B) Relationship To the Social Service Delivery System

Without question the Center is the major link between its clientele and the social service delivery system in Calgary. Many young people in Calgary, who are in need of help, would not seek that help despite the fact that a wide variety of resources are available, unless they were referred through and assisted by the Center. In the long

run, the social cost of these people not receiving help would probably be extremely high. In many cases, the results would possibly be fatal.

C) Impact On Community Service System

In general, the impact of the Center has been favourable. The relationship of the staff of the Center and that of other community services has done much to not only reduce the generation communications gap by developing understanding of the other generation by each group, but it has also developed in general a better understanding of the many aspects of problems related to drug usage. Some improvement would, however, be desirable in the relationship between the Center and some community services, in particular A.A.D.A.C. and the Departments' Crisis Unit.

D) The Funding Arrangements

The Center's funding has come from a variety of sources both voluntary and public. Direct funding assistance from A.A.D.A.C. has been the single most important source of funds. If the Center is to be established as a permanent service, then it would likely come to rely more totally on government funds in the future.

The manner in which funding has been made available has limited the flexibility of Center programs and the effectiveness of the Center. On the one hand, the Center has had to develop programs for which it could hope to get funds rather than concentrate on those programs which it knew from experience were most needed. Also, the indefinite nature of the funding resulted in uncertainties for the Center which seriously limited its ability to plan and program ahead. In addition, the delays which often occurred in the receipt of grants was a further factor in adding to these uncertainties and in enabling the Center to make financial commitments for services and programs on a regular consistent basis.

It is also evident that as the Center's role changed, the rationale for its funding as well as the rationale as to appropriate funding sources changed. The government agency

responsible for funding seemed to recognize this, but rather than finding ways of helping the Center to find new funding sources, put its efforts into developing information to support its contention that the Center wasn't needed as a priority, and hence shouldn't qualify for any government funding.

The evaluators would agree that A.A.D.A.C. was correct in its conclusions that it was no longer the most appropriate single source of funding since the Center dealt with a limited number of drug related problems when compared to the total service it provided. The changes in Center programming and in problems presented to the Center would suggest it has assumed a more preventive role as well as a more broadly based social service role. As such, the major portion of its funds would most appropriately come from the City under Preventive Social Services legislation enacted by the Province. It is however, possible to make a sound argument for A.A.D.A.C. to continue to provide some limited direct grant in Aid funding.

Fee-for-service funding would not be appropriate for the type of service provided by the Center. The bureaucratic requirements of such an arrangement would destroy the informality, the confidentiality and the anonymity which is seen as so essential in reaching the clientele served by the Center.

The proportion of funding which might appropriately come from A.A.D.A.C. would be approximately 20%. The last statistics produced by the Center indicate approximately 40% of the contacts are for drug or drug related problems. However, these initial contacts lead to the provision of other services to a substantial portion of this clientele. We estimate this reduces the actual drug related services to the above figure.

E) STAFFING

The present policy of comprising the staff of professional, semi-professional and para-professional people gives the Center a well rounded, flexible approach to their programs while adding the vitality of youth and the desire to help others in trouble. This policy should be continued.

F) IMPLEMENTING STRUCTURE

By operating through a community board incorporated under the Societies Act, the greatest amount of public participation is encouraged. This appears to be the most desirable structure to implement this type of program within the mosaic of the social service delivery system in Calgary.

G) COMMUNITY SUPPORT FOR THE CENTER

The Center enjoys a good reputation and good support in the community generally. This support can be divided into two segments, the support of the general public and the support from local politicians and officials and from the local service system. With only several exceptions, persons interviewed by the Evaluators gave their complete backing to the Center. It has largely been this support which has enabled the Center to press its case vigorously and rather effectively with the provincial government. It has also been this support which has ensured the Center's successful operation in the past and which allows it to continue operations at the present time. At this level, the Center is seen as having a positive image, having credibility, and as a place where people and agencies are prepared to, and do refer people with problems related to the Center's area of service.

The results of a telephone interview also indicate that the Center has good general public support. The Center is well known in Calgary with 79% of those persons contacted indicating they had heard of the Center, and 60% indicating the Center would be a good place to go for assistance if they had a drug related problem or crisis. The degree to which the public image of the Center was positive was directly

related to the age of those interviewed (see Appendix E Table 9) Those age groups having the highest potential for drug related problems or crises also had the most positive image of the Center, suggesting that the Center does, or potentially has the capacity to reach the clientele most likely to have problems related to the services which the Center provides. (For further details, see Figure 14, 15, Appendix E and statistics summarized in Appendix E under 3, 4, & 5).

H) COST BENEFIT ANALYSIS

The cost of providing the services of the Drug Information Center are somewhat less than would be the cost to provide similar services through an existing government agency. This can be demonstrated by a simple evaluation of the staff and other costs which would have to be assumed by government. In addition, if a government agency were not able to mount a large core of volunteers (and this is a good possibility) as the Center has been able to do, these services would also have to be provided by paid staff, further escalating service costs.

The other factor in the cost picture which is more difficult to evaluate is related to the possible delay by the Center's present clientele in seeking services until such time as their problems reach serious portions. This could increase demands on present long term treatment facilities and have the effect of further increasing overall service costs. There are also other factors such as policing, lost productivity of emotionally crippled persons, increased public assistance costs, etc. which would have to be considered to arrive at a valid cost comparison between the present approach to providing service i.e. through the Center, and the suggested alternative, i.e. through a government agency.

SECTION VII RECOMMENDATIONS

Based on the Findings and Conclusions drawn by the evaluators, the following recommendations are being suggested for the consideration and possible implementation of the Minister and the Board of the Center.

I. The need for an agency such as the Center and for the type of service it provides is as valid today as it was in 1969 when plans were first being made to cope with what at that time was a serious unmet need in the area of drug and drug related problems. The Center's approach should continue to be flexible, open and informal to enable it to continue responding to the changing perception society and individuals have of their problems and needs, as well as to actual changes in need which are taking place.

Even though drugs are not the major problem or concern being dealt with by the Center at this time, the Center's clientele has not changed substantially. It includes the counter culture , the alienated and others who are not comfortable or prepared to seek out more traditional services. The evaluators support the Center's efforts to broaden the range of crisis services it offers to this group to broadly deal with their crisis problems rather than just to concentrate on drug related problems.

II. The evaluators' findings however, do not support the concept that the Center should or could become a broadly based community crisis, information and referral service available or focused at the total community population. Findings suggest that the Center has had a youthful clientele which falls into the categories identified above. Even at times of maximum publicity, the Center's clientele have not changed substantially, i.e. efforts to reach out to other groups in the community have shown little by way of results. In addition, the evaluators believe that there are a number of different groups in the community who require crisis services and that such services cannot be

satisfactorily provided by one agency. In some cases, the service must be provided by that agency having legal responsibility and in other cases, the different groups of clientele are not compatible, or can be best dealt with by an agency who has responsibility for, and expertise in working with these groups.

If the Center were to be successful in reaching out to some of these other client groups, it would likely have to change its image and its mode of operation. The evaluators believe that this would likely result in the Center losing contact with that client group it is now serving. This would be unfortunate since the Center has developed rapport, communications channels, and expertise in working with this client group. Further, no one else is presently serving this client group and there is no evidence to suggest that any other existing agency would likely be able to do so effectively.

III. Generally, the communications and relationships between the Center and other agencies are good. However, there is a need for improved communications between the Center and several of the community agencies with which it has or should have a close working relationship. In particular, we would suggest that the Center consider an exchange program with agencies such as the Renfrew Detoxification Center. This exchange program should be part of staff and volunteer training and orientation and should, as well provide some opportunity for follow up contacts on a periodic basis. Staff and volunteers of both centers could spend some of their training period at the other agency. As well, each staff or volunteer should have an opportunity to spend further time working at the other agency on a regular periodic basis for follow up. A similar arrangement might be worked out with several other agencies which provide crisis services.

We believe this would help keep staff and volunteers of various agencies including the Center, better informed of the relevant services each have to offer and would considerably improve working relationships and liaison between agencies.

IV. The Evaluators would suggest that the City Social Services Department should have primary responsibility to ensure that there is sufficient co-ordination among the various crisis intervention services being offered in Calgary. The evaluators do not see the housing of such services in one building as the way to accomplish or ensure that co-ordination. In particular, the Center should continue to be located in its present premises which it shares with more than a dozen other services which are probably most relevant to the needs of its clientele. If the Center were to move, accessibility to and co-ordination with these, important services would undoubtedly suffer.

The purpose of co-ordination should be to ensure that all crisis needs are being met and that no gaps or duplication in services exist. The Social Service Department of the City could have a monitoring role through its research staff. In addition, it may wish to structure some mechanism such as a joint planning committee of crisis agencies to meet periodically to ensure that plans and service implementation are being co-ordinated as indicated above.

V. The evaluators found no evidence to substantiate a claim that the Center services either overlap with or duplicate other existing services, i.e. that two services are serving the same individuals or client groups. Services provided by A.A.D.A.C. through the Renfrew Center appear to be largely directed to alcoholics and to a social-economic clientele not using the services of the Center. However, potential areas of overlap or duplication could arise and we believe have arisen in the past. Therefore, the City and the United Appeal should closely examine any new service proposals of a crisis nature which come forward to ensure that a need exists and that the need is not, or could not be met by one of the present services.

We noted that the services of the Center showed a substantial decline when the Mental Health Association initiated a short term crisis project. In this case, the Center's intake again increased to former levels when the service discontinued or became inactive.

VI. The evaluators are of the view that the local and senior governments should continue to provide major funding for the Center. Since the Center serves both a general prevention and social service function, as well as providing assistance with drug related problems, logic suggests there could be two sources of funding, i.e. Preventive Social Services through the City and A.A.D.A.C. directly. Based on present service statistics, such funding could be split as follows: City 80%, A.A.D.A.C. 20%.

However, since the same Minister is responsible for both Preventive Social Services and A.A.D.A.C., and since funding provided through either source, may be eligible for Federal cost sharing, the Minister may prefer to see all funding channelled through one government agency. In this case, the most appropriate channel would be the Department through the City, using Preventive Social Services legislation.

VII. The short term nature of funding for the Center up to the present time, has had the effect of forcing the Center to tailor its services to take advantage of funding sources available. This has limited the Center's flexibility and has as well impaired its ability to respond as needed to the service needs of the community and its clientele. To help overcome this problem, there must be some longer term commitment that there will be continued support for the Center's Services as part of the more permanent community service system. This is not to suggest specific levels of financial commitment but rather a statement of intention to support and budget for the Center's service on an ongoing basis.

VIII. The volunteer training program which has been one of the most impressive and effective functions of the Center's program should be continued and strengthened. Following the initial training period, there needs to be follow-up training to help people learn how to cope with concrete and practical problems, that they experience on a day to day basis, more effectively. This could take the form of

a structured and formal training program or might be dealt with by holding more frequent meetings with the volunteers.

Present staff - volunteer meetings concentrate on involving the volunteers in the administrative aspects and management decisions of the Center. This is a good practice and should be continued. These meetings could be augmented with additional meetings planned for the purposes identified above as well as for the purpose of insuring the volunteers are brought up to date on information about available services and resources which are relevant to the clientele they are servicing and as well, to discuss the appropriate use of these services and resources.

IX. The Center should continue to have a role in the drug information field, particularly as it relates to serving its own clientele, but also in terms of serving general youth groups and interested parent groups in the community. It is however, suggested that the Center work out an arrangement to have access to and use of the library and information services of A.A.D.A.C. This agency has the resources to develop and maintain its library and information services and has made impressive strides in this area during the past four years. The Center should not attempt to duplicate these resources, but should be able to use them and should invest its own resources in other needed service areas.

X. There is a need for agencies providing services similar to those provided by the Center, to develop and maintain a more uniform record keeping system. This would enable a more accurate assessment of both crisis and information needs, as well as services. Evaluating service requests, gaps in service, service duplication, or the individual services themselves will be difficult until a more adequate and uniform system of record keeping is devised. The evaluators do not wish to suggest what that system should be. However, this is one of the co-ordinating functions which the City could perform through its research department.

XI. The Center should develop a consistent publicity and advertising campaign to ensure that the community is at all times knowledgeable about its services and knows how to get access to them. The evaluators noted that whenever the Center received publicity, there would be a sharp increase in service requests. This may suggest that people only bother acquainting themselves with a service when they have a service need. When that need arises, they must have easy access to information or their service needs likely remain unsatisfied leading to more serious future problems.

XII. There are a number of other findings and conclusions in the report which suggest possible areas for action by the Center Board or for others concerned with the Center and its area of service. The evaluators would suggest that the Center establish a working committee, either independently or in co-operation with other services to study the findings and conclusions in more detail. Where practical, the Center should consider implementing such changes and making such improvements to its operation and service as are suggested.

APPENDIX A

Clients were subjected to an open-ended interview. The interviewer was seeking answers to the following questions:

1. What was the nature of the problem for which the client was seeking help?
2. How did the client hear about the Center and why did he/she come to the Center rather than somewhere else?
3. Did the Center help with the problem?
4. How did the Center help?

APPENDIX B

INTERVIEW FORM 1

HELLO: WE ARE CONDUCTING A VERY SHORT SURVEY TO
DETERMINE WHETHER OR NOT THERE ARE SUFFICIENT
RESOURCES IN CALGARY TO DEAL WITH CRISES
ARISING FROM EMOTIONAL PROBLEMS INCLUDING
PROBLEMS ASSOCIATED WITH DRUG USAGE. WE ARE
ATTEMPTING TO DETERMINE WHERE PEOPLE WOULD
PRESENTLY TURN FOR HELP IF THEY WERE FACED WITH
SUCH A CRISIS SITUATION.

1. HAVE YOU EVER HAD THE NEED FOR SUCH A SERVICE? YES _____ NO _____

2. IF NO, IF SUCH A NEED EVER AROSE, WHERE WOULD YOU GO FOR SUCH
ASSISTANCE? _____

2A.WHY? _____

(PROCEED TO QUESTION 8)

3. IF YES, DID YOU OBTAIN THE ASSISTANCE WHICH YOU NEEDED? YES _____ NO _____

3A. IF YES, WHERE? _____

4. WAS THE ASSISTANCE EASILY AVAILABLE? YES _____ NO _____

5. IF YES, COULD YOU EXPLAIN WHY? EQ: LOCATION, HOURS OPEN, ETC. _____

5A. IF NO, WHAT WAS THE PROBLEM? _____

6. DO YOU KNOW OF ANY OTHER SOURCES OF THIS TYPE OF ASSISTANCE? YES _____ NO _____

7. IF YES, WHY DID YOU NOT USE THAT SOURCE? _____

8. IF THE DRUG INFORMATION CENTER HAS NOT YET BEEN MENTIONED IN THE
INTERVIEW: HAVE YOU EVER HEARD OF THE DRUG INFORMATION CENTER? YES _____ NO _____

9. IF YES, DO YOU THINK IT WOULD BE A GOOD SOURCE OF ASSISTANCE? YES _____ NO _____

10. WHY?/WHY NOT? _____

11. WE WOULD LIKE SOME INFORMATION ABOUT YOURSELF:

A. ARE YOU MARRIED OR SINGLE? _____

B. ARE YOU A PARENT? _____ NUMBER OF CHILDREN _____

AGES RANGE FROM _____ TO _____

C. WHAT IS YOUR AGE? _____

D. WHAT IS YOUR OCCUPATION? _____

WHAT IS THE OCCUPATION OF YOUR SPOUSE? _____

APPENDIX C

DATA CARD A

DAY	MONTH	SHIFT	VOLUNTEER	MODE	CALL ABOUT	AGE	REFERRED BY	REFERRED TO	OTHER AGENCY	OTHER	OTHER	OTHER
0	0	1	1	0	PHONE	TALK	STUDENT	UNDER 16	SELF	PHYSICIAN	OTHER AGENCY	LSD
1	1	2	2	1	DROP IN	REFERRAL	NON STUDENT	15-20	FRIEND	FOOTHILLS	A.I.D.	OTHER HALUCINEGENS
2	2	3	3	2	BOTH	OTHER	NON STUDENT	21-28	PARENT	HOLY CROSS	OTHER SPECIFIED	PHYSICAL
3	3	4	4	3	OTHER	CALL FROM	RESIDENCE	OVER 26	DOCTOR	GENERAL	NO REFERRAL	MUSCLE STIFFNESS
4	4	5	5	4	SERVICE	YOUTH	CALGARY	FOOTHILLS	ROCKYVIEW	DRUGS INVOLVED	CURRENT USE	IRRITABLE
5	5	6	6	5	FIRST AID	SPOUSE	OUT OF TOWN	GENERAL	FREE CLINIC	ALCOHOL	HEAVY	CONVULSIONS
6	6	7	7	6	INFO	PARENT	TRANSIENT	HOLY CROSS	WITHIN CENTRE	CANNABIS	LIGHT	STOMACH CRAMPS
7	7	8	8	7	OVER NIGHT	OFFSPRING	SEX	ROCKYVIEW	PSYCHIATRIST	SOLVENTS	MODERATE	OTHER
8	8	9	9	8	CRISIS	OTHER	M	POLICE	CLERGY	BARBITUATES	NONE	BEHAVIORAL
9	9	10	10	9	COUNSEL	FIRST CONTACT	F	SOCIAL AGENCY	SOCIAL AGENCY	OPATES	ASSESSMENT	PARANOIDA
10	10	11	11	10	DROP IN	Y		FREE CLINIC	CITY AGENCY	STIMULANTS	LIGHT	HALLUCINATIONS
11	11	12	12	11	SHOWER	N		OTHER	COUNSELLING AGENCY	TRANQUILIZERS	MODERATE	DEPRESSION
12	12			12								WORSE

Response positions are to be marked in the following fashion in pencil. Erasures must be complete or they will indicate a response.

Additional information may be written on the back of the card in pencil — time and duration of contact, etc.

CALGARY DRUG INFORMATION CENTER

FORM 1042

DATA CARD B

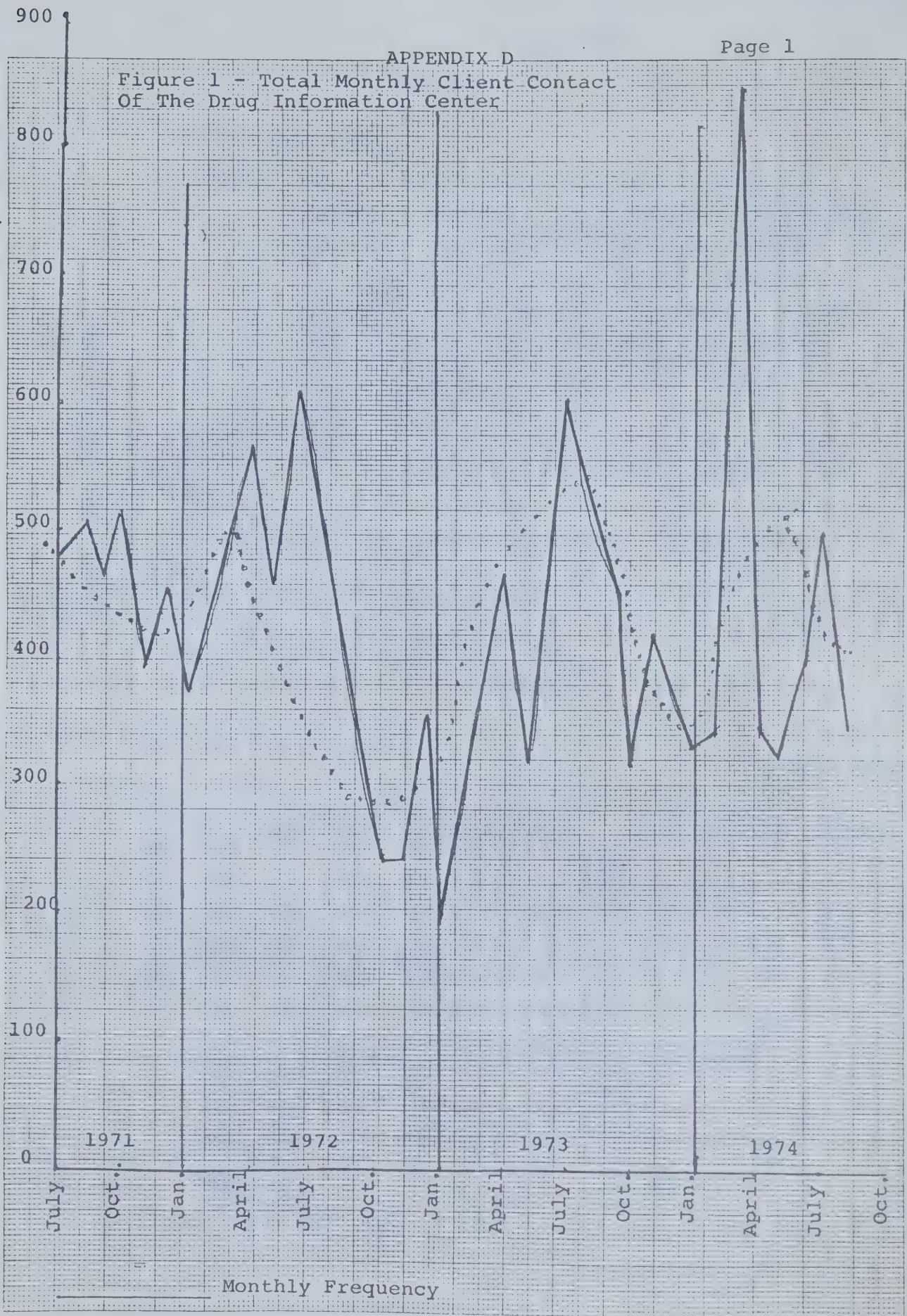
DAY	MONTH	SHIFT	CALL FROM	AGE	CALL ABOUT	SITUATION	SERVICE	REFERRED BY	REFERRED TO	PHYSICAL	OTHER INVOLVED	OTHER	OTHER
0	0	1	1	0	SELF	F	FIRST AID	SELF	PHYSICIAN	HOSTEL	ALCOHOL	OTHER SPECIFIED	LESS THAN 6 MONTHS
1	1	2	2	1	YOUTH	UNDER 16	DRUG INFO	FRIEND	FOOTHILLS	LOCAL SERVICES	CANNABIS	UNSPECIFIED	LESS THAN 1 YEAR
2	2	3	3	2	SPOUSE	16-30	GEN INFO	PARENT	HOLY CROSS	OTHER	SOLVENTS	BONE	1-5 YEARS
3	3	4	4	3	PARENT	21-28	DRUG CRISIS	DOCTOR	GENERAL	NO REFERRAL	BARBITUATES	CURRENT DRUG USE	OVER 5 YEARS
4	4	5	5	4	OFFSPRING	30-44	NON DRUG CRISIS	FOOTHILLS	ROCKYVIEW	ANXIETY	OPATES	DAILY	UNKNOWN
5	5	6	6	5	ADULT	45-65	DRUG COUNSEL	GENERAL	WITHIN CENTRE	HALLUCINATIONS	BETHADONE	LESS THAN DAILY	
6	6	7	7	6	UNKNOWN	OVER 65	NON DRUG COUNSEL	PSYCHIATRIST	DEPRESSION	OTHER	STIMULANTS	WEEKLY	
7	7	8	8	7	STUDENT	UNKNOWN	DROP IN	ROCKYVIEW	CLERGY	SOCIAL AGENCY	TRANQUILIZERS	LESS THAN WEEKLY	
8	8	9	9	8	EMPLOYED	Y	TALK	POLICE	SOCIAL AGENCY	HYPERACTIVE	PRESCRIPTION	OVERDOSE	
9	9	10	10	9	UNEMPLOYED	N	REFERRAL	SOCIAL AGENCY	COUNSELLING AGENCY	WITHDRAWN	OVER THE MONTH	UNKNOWN	
10	10	11	11	10	UNKNOWN	PARENT CALLER	OTHER	SCHOOL	OTHER AGENCY	OTHER	LSD	UNKNOWN	
11	11	12	12	11	SEX	M		OTHER	AID		OTHER HALUCINEGENS	LESS THAN 1 MONTH	
12	12			12	F	UNKNOWN							

THE CENTRE

FORM 1043

APPENDIX D

Figure 1 - Total Monthly Client Contact
Of The Drug Information Center



Monthly Frequency

..... Average Monthly Frequency Computed Quarterly

Figure 2 - Total Monthly Contacts For Information

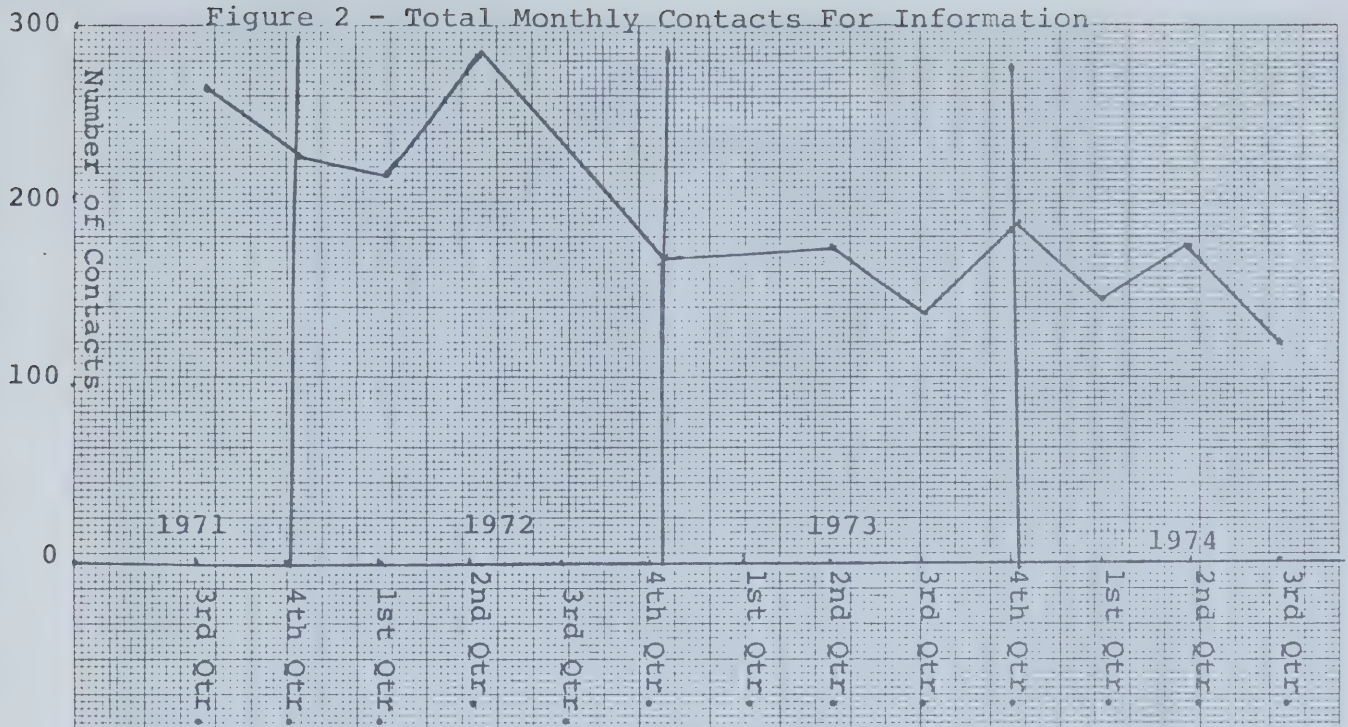


Figure 3 - Total Monthly Client Contacts for Crisis Intervention

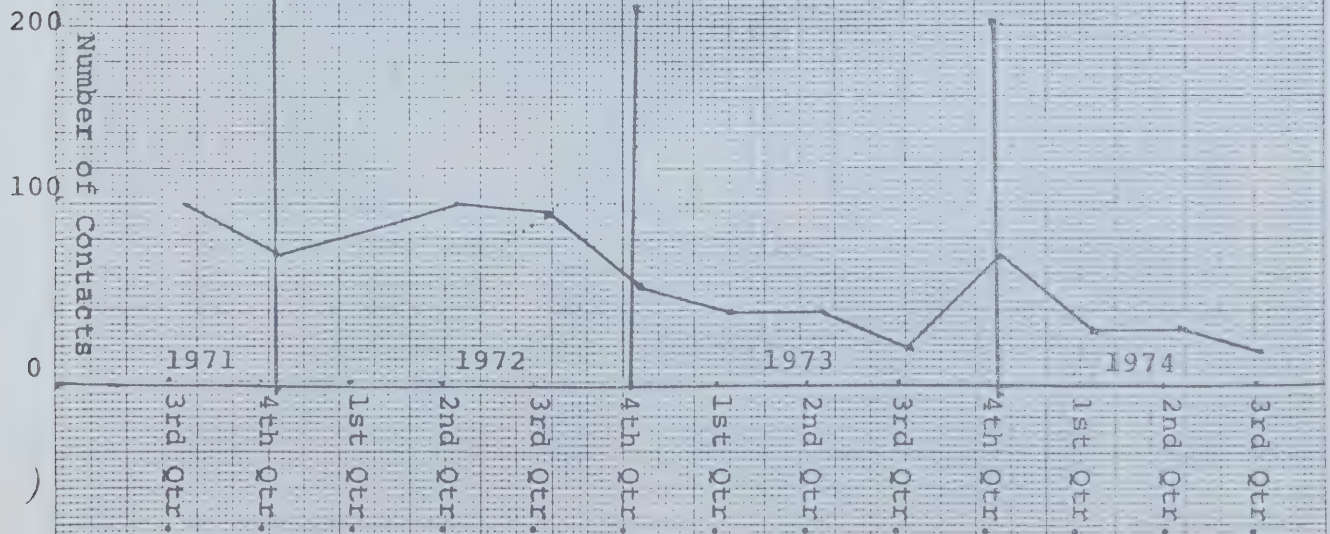


Figure 4 - Total Monthly Client
Contacts for Counselling

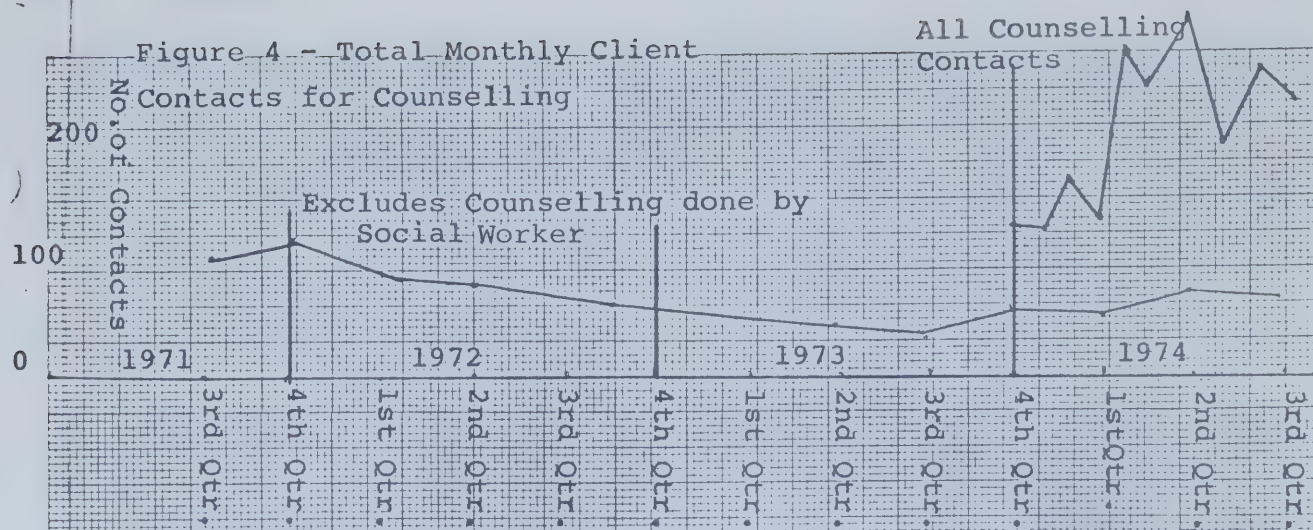
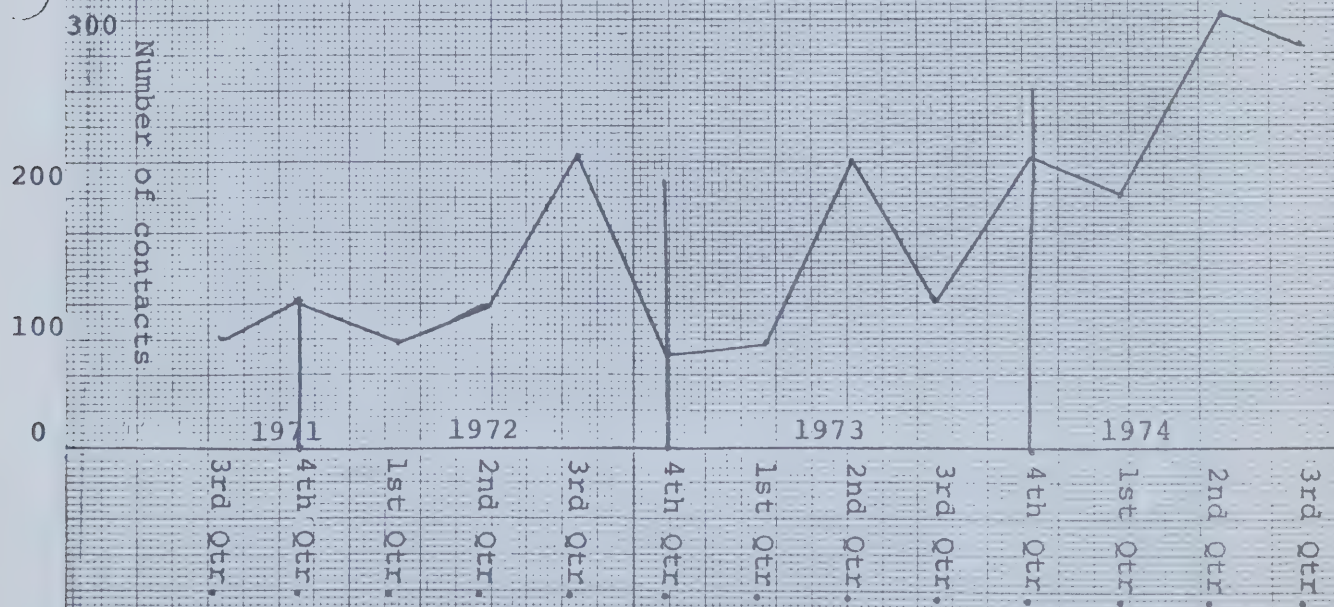


Figure 5 - Total Monthly Other Contacts



RESULTS OF TELEPHONE SURVEY

1) In response to question 1 "Have you ever had the need for such a service" only 7% responded affirmatively. They had sought a variety of sources of help, however, the sample was too small to draw any significance as to the quality of those services from the clients viewpoint. None of this sample had been users of the Drug Information Center.

2) In response to question 2, "If such a need ever arose, where would you go for such assistance?" The response was as follows:

		Average Age
I don't know	32.0%	
Family doctor	16.5%	37.6 years
Social Services	11.5%	36.3 "
Clergy or Church	5.5%	40.5 "
<u>Drug Information Center</u>	4.5%	35.5 "
Family Service Agency	4.0%	Sample too small
Hospital emergency	3.0%	"
A.I.D. Center	3.0%	"
A friend	2.0%	"
My family	1.5%	"
City Police	1.5%	"
A.A.D.A.C.	.5%	"
Alcoholics Anonomous	.5%	"
Legal Aid Clinic	.5%	"
Bug Desk	.5%	"
Y.W.C.A.	.5%	"
Telephone Emergency #911	.5%	"

3) In response to question 8, "Have you ever heard of the Drug Information Center?" the results were as follows:

	Frequency	Percentage
Yes	157	78.5%
No	<u>43</u>	<u>21.5%</u>
	200	100.0%

- 4) In response to question 9, "Do you think it would be a good source of assistance?" the results were as follows:

	Frequency	Percentage
Yes	94	59.8%
No	4	2.5%
I don't know	<u>59</u>	<u>37.7%</u>
	157	100.0%

- 5) The subjects responding to questions 8 and 9 can be characterized in 4 groups, three of which are large enough to draw significant demographic descriptions:

a) Never heard of the Center	Average Age 44.5 years
b) Heard of the Center but knowledge insufficient to form an opinion	40.5 years
c) Positive opinion of the Center	35.2 years
d) Negative opinion of the Center	Sample too small

* See Figure 14 Next Page

Figure 14 - Relationship Between Age and Awareness and Attitude to the Drug Information Center.

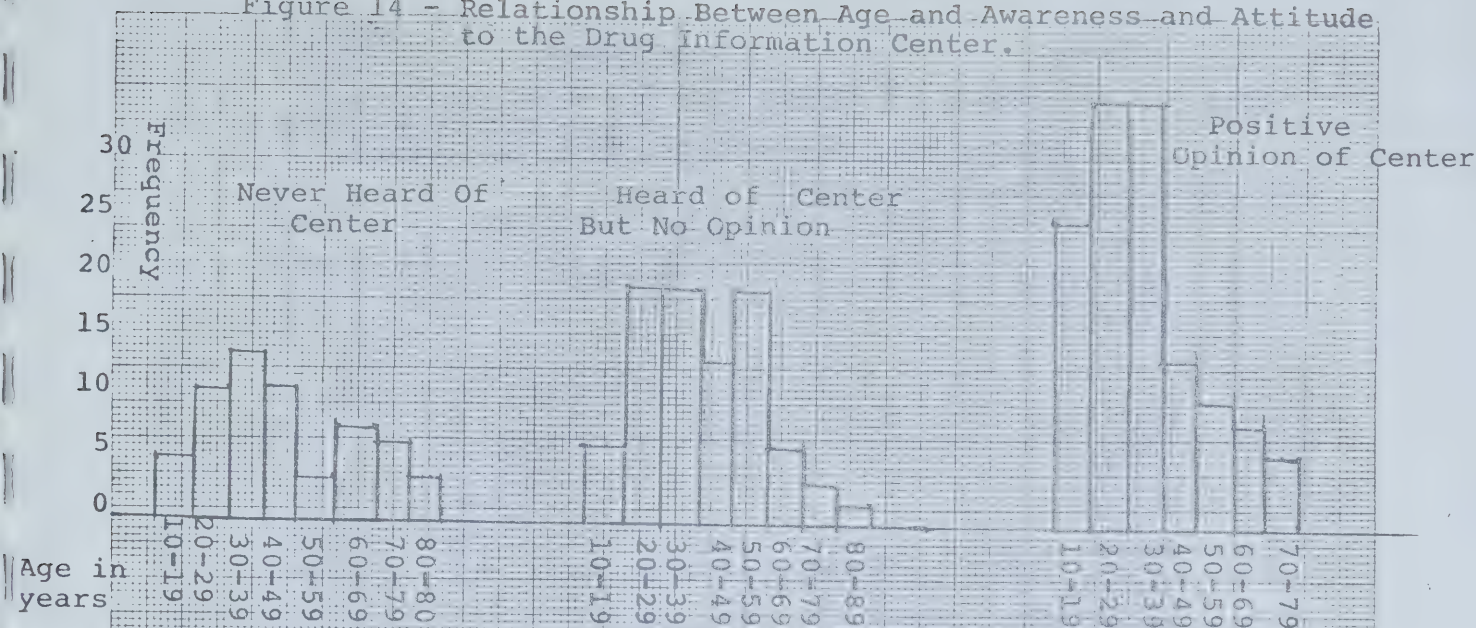


Figure 15 - Relationship Between Vocation and Awareness and Attitude to the Drug Information Center

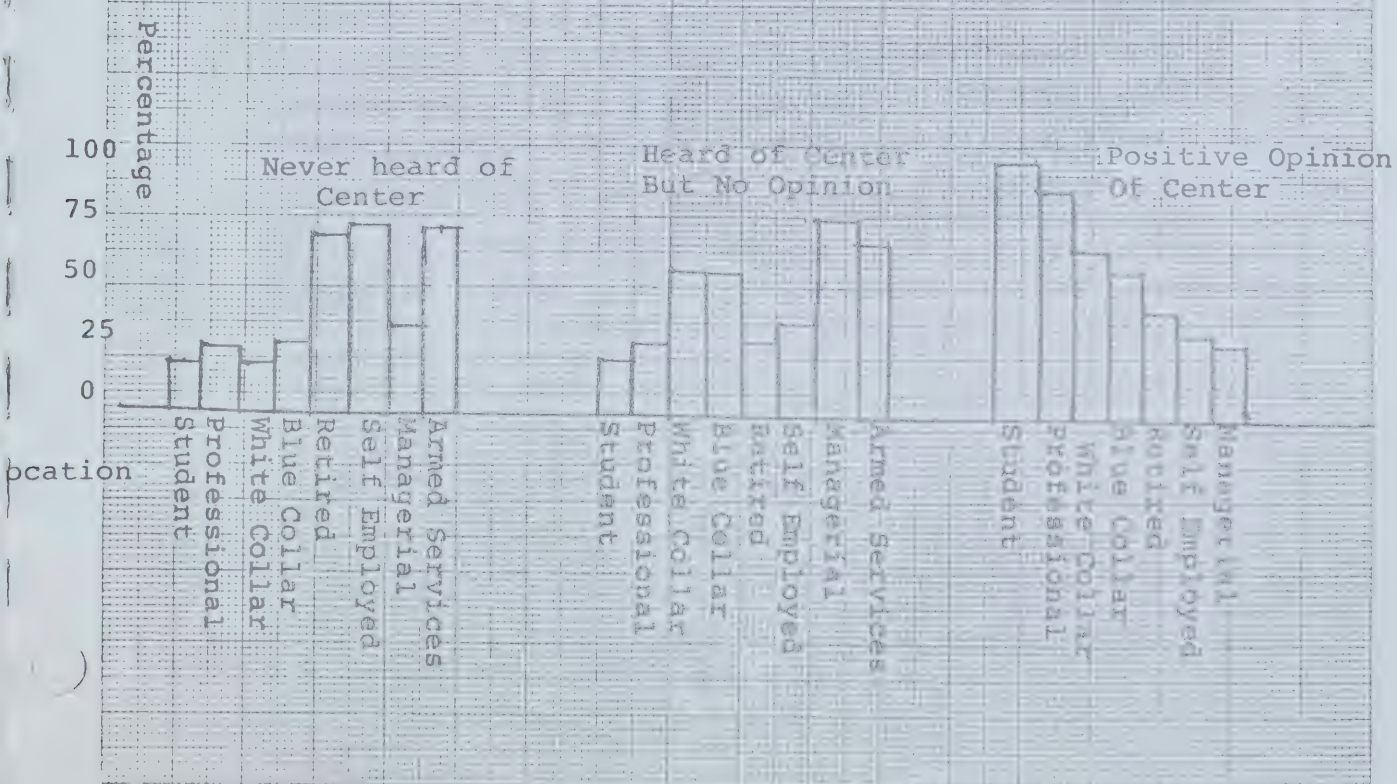


Table 9: Percentage of Sample that had both sufficient knowledge of and a positive attitude towards the Center by age:

Age Group	Percent of age group
10-19	70.8%
20-29	48.0%
30-39	47.1%
40-49	29.0%
50-59	30.4%
60-69	40.0%
70-79	40.0%
80-89	0

A greater percentage of single persons and parents with young children had both knowledge of and a positive opinion of the Center. Young people in general (under 40) showed this same trend and since more young people are single or have young children, this relationship appears to be more a function of age.

The other demographic factor which separated those who knew about the Center from those who did not was vocation. These results are shown in Figure 15. (See previous page).

APPENDIX F

Social Agencies interviewed:

1. Advice, Information & Direction (A.I.D.) Center
2. Alberta Alcoholism and Drug Abuse Commission
3. Alberta Mental Health Services
4. Bug Desk
5. Calgary Birth Control Association
6. Calgary City Welfare - Preventive Social Services Division
7. Calgary Family Service Bureau
8. Calgary Inter-Faith Agency
9. Foothills Provincial Hospital Emergency Ward
10. Foothills Provincial Hospital Psychiatry Department
11. Foothills Provincial Hospital Social Service Department
12. Catholic Family Service
13. Department of Culture Youth & Recreation
14. Juvenile and Family Court Services, Attorney General's Dept.
15. Holy Cross Hospital Community Services Division
16. Holy Cross Hospital Emergency Ward
17. The United Fund of Calgary
18. Renfrew Recovery Center
19. Young Men's Christian Association
20. Young Women's Christian Association
21. Canadian Mental Health Association
22. Salvation Army
23. Heroin Ends Life Prematurely (H.E.L.P.) Society
24. Womens Emergency Shelter
25. Calgary Self Help

APPENDIX G
VOLUNTEER TRAINING SCHEDULE

THE CENTER January Training Session
 January 18 - February 4, 1975

Saturday, January 18, 1975

10:00 a.m. - 12:30 p.m.: Policies & Procedures (Penny,
Michael - Center Staff)

1:30 - 2:30 p.m. - Pharmacology and Drug Treatment - Part I
(Bruce Martin - Center Staff)

2:45 - 4:30 p.m. - Pharmacology and Drug Treatment - Part II
(Bruce Martin - Center Staff).

Tuesday, January 21, 1975

7:30 - 8:45 p.m. - Alcoholism - (Mac Daglish: Alberta
Alcoholism and Drug Abuse Commission).

Coffee

9:00 - 10:30 p.m.: First Aid (Dr. Don Angus - Foothills
and Holy Cross Hospital).

Thursday, January 23, 1975

7:30 - 9:00 p.m. - Counselling - Introduction (John Cubberley
D.I.C. Staff).

9:15 - 10:30 p.m. - Counselling - regular clients (Betty
Maisey, D.I.C. staff).

January 24 - February 4, 1975

Big Brother Training Commences:

During this period, new volunteers will work shifts with more
experienced Center volunteers. It is recommended that at
least two training shifts be completed before the next
training session.

Tuesday, February 4, 1975

7:30 - 10:30 p.m. - Counselling - (John Cubberley - Center
Staff).

- all sessions begin at 7:30 p.m. promptly (except for the
Saturday session which begins at 10:00 a.m.).

APPENDIX H

VOLUNTEER INTERVIEW SCHEDULE

We are evaluating the services of the Calgary Drug Information Center. You could assist by answering the following questions:

1. Were you a volunteer worker?

Yes _____ No _____

2. When?

_____ 19 _____ to _____ 19 _____

3. Did you have any training before you started with the Center?

Yes _____ No _____

3A If Yes, describe _____

4. Did you receive any training?

Yes _____ No _____

4A. If yes, describe _____

4B. Was it the type of training you required?

Yes _____ No _____

4C. If yes, describe _____

4D. If no, explain _____

5. In what areas would training have been useful? _____

5A. Why? _____

6. Have you had any subsequent training?

Yes _____ No _____

6A. If yes, describe _____

Appendix H - Cont'd.

7. Has the training and experience you received while at the Drug Information Center been useful to you since you left the Center?

Yes _____ No _____

7A. If yes, explain, _____

APPENDIX I

RESULTS OF INTERVIEWS WITH CLIENTS

1) Number of clients interviewed.	<u>10</u>		
2) Condition of client as a result of using the Center's Facilities:			
	Clients opinion	Interviewers Opinion	Center's Records
Improved	90%	80%	81.3%
No Change	10%	20%	14.6%
Worse	0	0	4.1%

3) Problems presented to the Center:

Alcoholism	1
Death of Parent	1
Depressed & Suicidal	3
Depressed & Lonely	2
Heroin Addiction	2
Out-patient (Psychosis)	1
	<u>10</u>

Of the suicidal cases, two had taken an overdose of drugs.

4) Method of Referral to the Center:

From friend	2
From parent	1
From other relative	1
From Free Clinic	1
From Hospital	1
From Police	1
Self referral	3
	<u>10</u>

5) Nature of Treatment:

<u>Problem</u>	<u>Treatment</u>
Alcoholism	Provided companionship & emotional support.
Death of Parent	Emotional support
Suicidal	Long term counselling
Suicidal	Hospital referral & follow-up
	Emotional support

Appendix I - Cont'd.

5) Continued

<u>Problem</u>	<u>Treatment</u>
Suicidal	Emotional support
Depressed	Involvement in further education
Lonely	Provided companionship
Heroin Addiction	Hospital referral & follow up
	Emotional support
Heroin Addiction	Hospital referral, involvement in further education & follow up
	Emotional support
Out-patient (psychotic)	Providing emotional support to enable client to remain an out-patient rather than be institutionalized

